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MENTAL HYGIENE

MENTAL HYGIENE aims to bring dependable information to everyone interested in mental problems. Here are original papers by writers of authority, reviews of important books, reports of surveys, special investigations and new methods of prevention and treatment in the broad field of mental hygiene and psychopathology. Our aim is to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials and students of social problems find it of special value.

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Articles

Book Reviews

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Mental health versus mental illness

Mental illness has been recognized as a major social problem. As such it is the subject of many professions, combatted by many organizations, discussed by millions of people. As health represents the opposite of illness, mental health emerged as an area of concern equal to the one of mental illness. It is taken for granted that the two represent one continuum with mental health and illness occupying the opposite poles. This method of viewing the problem is semantically correct and appears logical; in fact, so much so that only recently doubts have arisen whether this is not the wrong way of looking at it. Could it be that mental illness covers a variety of different phenomena, some of which are related to mental health and others not? For example, does the loss of mental health always result in mental illness? Does recovery from mental illness mean that the individual is mentally healthy? Increasingly it has become evident that the logical dichotomy, mental health—mental illness, creates considerable confusion and contradiction. Many an observation of human behavior makes little sense when viewed as a point on the health-illness continuum. It therefore becomes necessary to attempt to replace the present-day conceptualizations (health-illness dichotomy) with different ones, in the hope that a new, better fitting, more logical order between observations will result.

In the following paragraphs, some arguments will be presented with the purpose of establishing different continua by which to order observations. No claim is made that

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the speculations are either new, factual or true. The sole purpose of the speculations is to permit new polarities which, when applied to observations, will reduce the number of confusions and unclarities which beset the mental health-illness frames of reference.

Recent progress in the understanding and treatment of mental illness has been partly due to the demonstration around the turn of the century that mental illness was not an isolated phenomenon, that illness in many, but not all, ways represented deviation from normality. At present it may prove fruitful to emphasize less the common denominator and to stress more of the possible differences between the states of mental health and mental illness.

In the following, it is postulated that mental health and mental illness represent two separate and distinct entities which require the ordering of facts along two different continua: (1) the mental health continuum with the polarities of "mental health-mental injury"; (2) the mental illness continuum with the polarities "susceptibility to mental illness-mental illness." Individuals who are ranked on the "susceptible-mentally ill" continuum will be designated as "infirm," those on the "mentally healthy-mentally injured" continuum as "healthy."

It is hypothesized that mental health is represented by an individual whose psychic organism is capable of performing a variety of fundamental tasks in an adequate manner. The criteria for adequacy must be broken down into two main components: one, the individual's subjective experiences expressed in statements such as "I am fairly happy," "life is all right," "that's the way life is," etc.; two, the standards of society which demand that an individual should not demonstrate in public "undue" unhappiness, pain or stress. Notice that society does not prescribe individual degrees of satisfaction but rather limited degrees of freedom to express dissatisfactions. The healthy (which does not necessarily mean normal) psychic organism provides, among other functions, for adequate emotional satisfaction, as well as reasonable safeguards against emotional stresses. When the stresses become too great and transgress the capacities of a given psychic organism to ward off the environmental intrusions, the organism will break down. This is part and parcel of a well functioning organism demonstrable in all areas of biological functioning. It is equally demonstrable and is the essence of a healthy organism that following a breakdown of its structure it will immediately attempt a variety of adjustments until restitution is accomplished.

A bereaved person will grieve and his despair may drive him into despondency, but while he is thus incapacitated the beneficial processes of repression will dim the power of memory. The pain will slowly ebb and peaceful, temporary indifference may aid the recovery. The combat soldier overwhelmed by fears and tension and hunger and sleeplessness may retreat into physical illness or his thinking may demonstrate mental aberrations. But simultaneously he replenishes his ego and with some sleep, some food and some human understanding he resumes the burdens of facing up to his inhuman task.

The ceaseless struggle for restitution, for adjustment and recovery, is what constitutes health. The fact that a breakdown has occurred represents nothing but a special incident in the process of living. The healthy man can become temporarily incapacitated as the result of undue stress; his recovery, depending upon circumstances, may require various amounts of time; his symptomatology may resemble the one displayed by the mentally ill—but here the similarity rests.

The healthy will spontaneously provide for his own recovery; he will eagerly respond and accept all help offered to him; he will follow all the possible paths toward health. For the purpose of describing the state of breakdown of the mentally healthy person, the term "mentally injured" will be used to distinguish this group from the "mentally ill."

The "mentally healthy" man is seen rarely by those studying mental illness. He usually treats himself successfully. To cite an example: If he is depressed, he will think about possible causes. Consciously and/or unconsciously he will find the source of discomfort. Unable to establish cause and effect relationship, he may divert his discomfort. If unsuccessful, he will seek professional help. He rarely needs but a few hours of contact to cope with his problems. He is more often counseled than therapized. If his situation is aggravated to the point of contact with the mental illness specialists, he frequently recovers quickly. This situation gives rise to the confusion centered around the problem of "spontaneous recovery."

To use an analogy, the "mentally injured" man resembles an individual physically ill who has suffered injury in the form of a broken bone or an invasion by a bacteriological agent. The organism's reaction will be a vigorous and healthy one, the bone will mend, the invader will be attacked by agents mobilized within the body.

The second continuum postulated is "susceptible-mentally ill." This concept is based on the assumption that a large group of individuals lack the quality of continual and spontaneous self-recovery. This may be due to a variety of causes: hereditary, genetic, developmental, structural and others. The one to be emphasized here consists of weaknesses or defect in the structure of the psychic apparatus. Such an individual may by chance or design have a life pattern where stress is minimal. He thus may never become sick, is never seen by the mental-illness specialists. As an example, let us consider a truck driver with severe personality disturbances—in psychiatric terms, an ambulatory schizophrenic. The occupation of truck driving keeps him steadily on the road. For weeks on end he sees his family on occasional weekends only, minimizing the pressure of close emotional ties. He is mostly alone when driving. He is constantly on the move, on the move from his internal pressures. Only in this specifically suitable environment can he live at a precarious peace with his environment. In the terms of this paper, he is "infirm."

Recent studies [1] have demonstrated that there exists in the population a large number of individuals who resemble greatly mentally ill people in the mental hospitals. What keeps these individuals outside of the hospital is a fortuitous arrangement of living conditions, permitting a precarious balance between their defective response to stress on the one hand and selected stress-free environment on the other. If this balance is upset, the result is recovery-resistant mental illness. The mentally ill person lacks the driving quality of self-recovery which permits numerous patterns of adjustment to be explored until the one fitting the situation is discovered. This lack need not be, necessarily, one of inability to create adequate adjustment patterns; it may rest in the lack of strength to apply and adhere

[1] Nyla J. Cole and others, "A Survey Assessment of Mental Illness—Community Rates. Attitudes and Adjustments," presented at the annual meeting of the American Medical Association June 12, 1956 in Chicago.

Dorothea C. Leighton, "The Distribution of Psychiatric Symptoms in a Small Town," *American Journal of Psychiatry*, 112(9, 1956), 716–23.

to potentially successful adjustments. Such an instance is demonstrated by an "infirm" who has knowledge of the fact that he uses fantasy as a replacement for reality but who lacks the strength to forego one and trust the other. Whatever the causes, the mentally ill man does not recover by his own efforts. On the contrary, he is unable to use help offered to him; he is resistant to improvement.

Using again an analogy, the mentally ill person may be perceived as an individual whose bones, once broken, show no inclination to knit, whose organism does not mobilize to combat and eject foreign bacteriological invaders. Osteoporosis is a condition within the organism, independent of the individual breaking a leg. Occasionally an accident may lead to the discovery of a permanent, existing condition. The potentially mentally ill person—that is, the infirm man (who may be normal according to all social criteria) who lives within the limits of his stress tolerances—is always susceptible though he never may become actually mentally ill.

Both the infirm and the healthy to a different degree can endure stress, can break down, can present similar symptomatology in the course of the breakdown. What differentiates them is their reaction to the breakdown. For the healthy it represents a transitory state of reduced adjustment; for the infirm it marks the aggravation of his chronic state. For the healthy, the breakdown marks a state of reduced health; for the susceptible it often means the onset of overt chronic illness. The conclusion emerging implicitly from this formulation states that the healthy, barring toxic or extraordinary environmental stresses and excepting metabolic or physiological changes, never will become mentally ill. Conversely, the infirm, barring extraordinary therapeutic or other interpersonal influences never can spontaneously gain mental health. Whether this outgrowth of our assumption corresponds to fact is open to debate. On the other hand, for the purpose of investigation, such a hypothesis is tenable and possibly even desirable.

The contemporary criteria of distinguishing between absence and presence of mental illness are many: to mention only a few, reality testing, degree of regression, logical categories, stimulus-boundedness and more. In the preceding paragraphs the concept of "self-recovery" versus "non-recovery" was discussed as an added and possibly useful criterion of differentiation. It is postulated that this criterion is based on the assumption that self-recovery is the consequence of a fundamentally intact organism, while "non-recoverability" is the result of deficiencies and/or lacks in the growth and development of the psychic structure. The observation of phenomena, which at present is done under the one heading of mental illness, should be expanded into two and possibly more categories.

The large number of spontaneous recoveries of so-called mentally ill people, reported by all investigators, tends to indicate that in the terms of this paper the number of "mentally-injured" people is very large while the number of those belonging in the "infirm-mentally ill" category is much smaller. Under the strain and stress of modern living, our society does not become progressively more insane; rather, individuals have more mental accidents than they used to have—not unlike the fact that more cars, better roads and more horsepower produce more car accidents.

By emphasizing to the mentally healthy that he must preserve his health because the alternative is mental illness, he is misinformed. His efforts are guided into the wrong direction, for his danger lies not in

becoming ill. In fact, by being cautioned only against the nemesis of mental illness, he is being deceived about his real danger, which is chronic, incapacitating malfunctioning.

The healthy man who is familiar with the symptoms of mental illness may reason, "I know I am not mentally ill; therefore, I am healthy." Instead he may be in between health and injury. Let us call the individual who is not healthy but at the same time far from injured—the handicapped. The handicapped may live his life beset with neurotica but he learns to tolerate and accept them. Potentially productive, he may waste his energies in struggling with his emotional impediments. He may never experience happiness, being satisfied with the absence of disturbance; he may co-exist with his wife and family rather than live with them; he is never quite satisfied, frequently tired, never happy, never quite unhappy. The mentally handicapped man is rarely seen in the office of the psychiatrist; he is filling the waiting rooms of physicians presenting a host of somatic symptoms.

It is difficult to estimate the number of individuals who fail to achieve minimum standards of mental health. As yet, society fails to establish standards of emotional efficiency and well-being comparable to those set for physical well-being and health.

In terms of research the necessity of separating mental health problems from mental illness problems is even more imperative. Studies dealing with various groups of mentally ill people number in the thousands; the number of studies on normal healthy functioning individuals published by psychologists and psychiatrists is below a hundred. Basic research in that direction has been undertaken by the Armed Services. Some research done in the field of education contributes to an understanding of healthy functioning. While the money allocated for mental illness has increased greatly, money for mental health research is hard to obtain.

In teaching, the situation is similarly one-sided. Clinical psychologists, psychiatrists, psychiatric social workers, nurses and many other professionals are grounded in abnormal behavior associated with mental illness. The courses in mental hygiene offered at present by many curricula consist in the main of material structured toward or gained from mental illness perspective.

The mental-illness specialist is faced with two different challenges: (1) the treatment, widely studied, of the mentally ill; and (2) the problem of the mentally injured. The latter, diagnostically and therapeutically, is still identified as a special case of mental illness rather than as a condition of diagnosis and treatment on its own. It may well be that radically different therapeutic procedures will emerge from each group. Therapeutic procedures of benefit to the mentally ill may be detrimental to the mentally injured, and vice versa. Prolonged hospitalization may be required for the mentally ill, but may be damaging to the injured. Intensive post-hospitalization care may be indicated for the ill, but counter-indicated in the convalescing injured. The sensitive ill may require protection from the harsh environment; the injured may require earliest exposure to it. Many examples could be provided from existing clinical practices fitting into this scheme of thinking, instances where treatment decisions are based on consideration of the patient's fundamental personality structure.

The mental health specialist, according to the ideas expressed in this paper, can enter the social scene only when mental health is recognized as a social and scientific problem in its own rights and merits. Once the division is accomplished, numerous professions will enter into the training of the

mental health specialist. Foremost among them, it is hoped, will be the psychologist. This trend in psychology emerges clearly from the Stanford Conference on Psychology and Mental Health held in 1955.[2]

SUMMARY

Viewing mental health and mental illness as opposite poles of the same continuum has resulted in considerable confusion and contradiction. This viewpoint has tended to impede progress in the understanding of mental health.

This article postulates that mental health and mental illness represent two separate and distinct entities which require the ordering of facts along two different continua: a mental health continuum with polarities of "mental health-mental injury" and a mental illness continuum with polarities of "susceptibility to mental illness—mental illness." It is further postulated that a person because of genetic or early environmental factors will place on one or the other continuum. If he places on the "mental health-injury" continuum, then (1) he will never become mentally ill unless extraordinary circumstances intrude; and (2) he has the power of self-recovery from stress. If on the "susceptible-mental illness" continuum, he lacks the ability to recover spontaneously when and if he becomes mentally ill (barring extraordinary therapeutic influences). Radically different educational, therapeutic and follow-up procedures may be indicated for each group.

Mental health as a workable social and scientific goal can emerge only after it has been clearly separated from the problem of mental illness.

[2] Charles R. Strother (ed.), *Psychology and Mental Health* (report of the Institute on Education and Training for Psychological Contributions to Mental Health held at Stanford University in August 1955), Washington, American Psychological Association, 1956.

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The interpretive and summing-up process with parents during and after diagnostic studies of children

The staff of the Guidance Center of Buffalo, in its diagnostic studies of emotionally, physically or mentally deviant children, early became aware of the large number of parents who had been running from one diagnostic facility to another, sometimes over a period of years, unable to accept the professional advice they had sought. Since many of the previous studies had been made by reputable diagnosticians, parental inability to accept the findings could not be explained solely on the basis of inadequate diagnosis or parental distortion. There were times when there had been incomplete or inadequate diagnosis or when explanations to parents had been too brief or too technical, but these were at a minimum. A careful study of cases that did not fall into that category revealed that the greater part of parental inability to accept diagnostic findings was based on certain underlying dynamic considerations within the family constellations.

A generalization that can be made is that parents intuitively sense that their child is mentally or physically different or severely emotionally disturbed. They develop intense feelings of failure and personal inadequacy. The presence of the child in the home furthers these feelings. The parents react in accordance with their individual and collective security and maturity. Mature parents, though hurt, are able adequately to accept the child and meet his physical and emotional needs. Less mature parents, or parents who have conflict in their relationship, react quite differently. They have normal parental feelings for the child but feel guilty because of incomplete or ambivalent acceptance of the child's condition. The child may appear to be normal in specific respects and deviant in others. The parents have difficulty in equating the differences of functioning. They are confused by this and by hollow reassurances of relatives and well meaning friends. They witness failure of their many efforts to meet the needs of the child. The repeated frustrations lead to mounting negative feelings and to a parent's giving up in some situations. The guilt, anxiety and confusion call

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forth self-protective defenses which partially block him from giving freely of himself to the child or to the other parent. One parent may play down observed signs of deviation in attempting to make things easier for the spouse and for himself. However, the similarly upset spouse may interpret this as indifference, callousness or lack of concern, and react strongly. One parent may claim complete blame for the condition and bear the burden in masochistic fashion. He may so dote on the child that the other parent reacts to feeling shut out of his own family. The child in turn reacts as if he interprets as rejection the well-intentioned but inadequate supply of love, acceptance and understanding. Thus the stage is set for conflict in the relationships in the family.

In attempting to handle mounting feelings people characteristically present a wide variety of defensive patterns. We could roughly classify in three groups the parents of the children studied:

• *Those who protest that the child is normal.* Fathers seem to protest louder than mothers. The parents may subject the child to undue educational and social pressures, and involve him in cultural pursuits far beyond his capacity. For example, a severely mentally retarded, brain damaged and somewhat physically handicapped girl was put into a dramatics and dancing class. The teacher finally forced the protesting parents to remove the child. The parents continued to pressure other teachers to take the child into a class of normal children.

This group of parents seems to use denial or reaction-formation-like ego defenses against recognition of the handicapping condition. These are primarily for their individual self-protection and for the protection of family status in society. They are afraid to face the marital partner or society with their true awareness for fear of hurting the spouse and possibly receive a deeper narcissistic wound in return. The show of overprotectiveness is actually nonprotective in that the limited child is forced to function as a normal child. These parents are as a rule very inconsistent in their handling of the child. Many of the children are as anxious and confused as are the parents, and evidence reactive or deeper emotional disturbance.

• *Those parents who accept that there is something wrong with the child, but who hold to a diagnosis that is hopeful or emotionally acceptable.* The parents of Paul, a 7-year-old, held that he was physically and intellectually normal but that he was an emotionally disturbed child. Study revealed the boy to be brain damaged and severely mentally retarded.

The parents of this group hold to a condition which is more ego acceptable to them and which may be treatable. Through their protestations they evidence insecurities and intolerance of the true findings. However, they reveal their true awareness of the condition as they describe the child. The parents of Paul, while still protesting, presented an accurate picture of the brain damage and the mental retardation. They were very upset at having given birth to a severely impaired child. For self-protection they partially blinded themselves by saying symbolically, "Paul is not severely impaired. He has a condition which is reversible. We got him into this and we can help him."

With parents of this group there is a basic psychological dynamic for denial of realities. They do not protest that the child is normal and they do protest that there is something wrong with the child. However, they do not find the true diagnosis tolerable. They substitute for it one which is more acceptable and not so final.

• *A few parents are overly accepting of the diagnosis.* They force the symptoms on society and on the diagnostician. There is so much pressure to "tell all" that one gets the feeling that the parents are talking about something inanimate—a symptom. The empathy for the child has been blocked by the narcissistic blow of discovering that the child is "different." For self-protection the parents seem to say, "We know that our child has this condition. We know all about it and accept it. We are doing everything possible to help him. Our actions and understanding show that we love, understand and fully accept him. You can't and shall not tell us anything." This is a surface reaction aimed at disarming and fending off others. It helps the parents to retain their disturbed *status quo.* The natural parental feelings are present, but are submerged and bottled up.

For example, the parents of Sally, an 8-year-old girl, asserted that she was normal except for her blindness. They brought out supporting evidence and in a very intellectual way talked on blindness and all that they had done for Sally. As they talked about Sally herself, and as they were seen with the girl, a coldness and distance was felt in the relationship which had essentially become a relationship between the parents and "blindness" rather than between the parents and Sally.

There is both overlapping and variety of dynamic patterns in the three groups listed, but a common factor that emerges is the anxiety and fearfulness these parents have in facing the diagnostic findings. They want and appreciate an honest and sincere statement of findings in their child but have been psychologically unable to absorb or apply the findings. Thus they become "shoppers"—that is, they are "shopping" ostensibly for a diagnosis of their child but in reality for help for themselves.

Recognition of the dynamics of the parental disturbance in these cases suggested a diagnostic approach which has proved to be a satisfactory method of preventing "shopping" in most cases. This paper represents the fruits of five years of self-critical study and practice in over a hundred such cases.

THE DIAGNOSTIC PROCESS

The diagnostic process consists of the child's being seen by the psychologist, psychiatrist and varied consultants as needed to gain a full understanding of the condition in the child. The psychologist sees the child in three or four or more sessions in administering a battery of psychological tests. The child's intellectual capacity, with the range, present level and possible potential of functioning, is ascertained if possible. Specific learning problems and special abilities and disabilities are studied. Ego strengths and weaknesses and total personality functioning are evaluated. The psychiatrist sees the child in from one to three sessions in gaining a clinical impression of the degree of emotional upset, and in doing a cursory physical and neurological examination. The child is referred to consultants or clinics for special studies indicated by our evaluation of the child.

In most cases, the parents are involved in the diagnostic process through meeting with a psychiatric social worker or with the psychiatrist during each visit of the child with a diagnostician. Some criteria of selection of the staff member to work with the parents are these: the level of skill required, the degree of disturbance in the individual parent, the degree of disturbance in the parental and parent-child relationship, the complexity of the medical aspects of the problem, and the feelings the parents have toward the medical profession.

The approach to the parents is not one

of history getting; it is, rather, one in which they become deeply involved. The parents are helped to reveal, examine and gain an understanding of their anxieties, fears and confusions in relationship to their own disturbed feelings and the feelings provoked by the child and his condition. This is accomplished through the worker's dynamically pointing up the expressed or implied feelings which become evident during the interview. Also, the parents are helped to bring out their true awareness of the child as the worker utilizes information transmitted by the diagnostician in brief conferences following each contact with parents and child. Similarly, the diagnostician may utilize with the child dynamic material gained from the parents and from the diagnostic evaluation. The brief conferences serve to keep the process constantly integrated. By the end of the diagnostic process parents have faced and gained understanding of their problem and that of the child. Thus they are prepared for full acceptance of the diagnosis and recommendations.

The summing-up interview with the parents follows an evaluation conference in which the findings of the various staff members are integrated. The psychiatric social worker, psychiatrist or psychologist may individually or in combination meet with the parents. In this interview the social, emotional, intellectual and physical findings are shared and fully discussed with the parents. At the close of the interview the parents are helped to outline recommendations. Conferences may be held with schools, social agencies, physicians or others. Contact is kept with the family through follow-up at stated intervals, and in some cases a re-evaluation is recommended after a specific lapse of time.

To illustrate this process, two cases are presented with the focus on the work with the parents. Implicit in the illustrations are the dynamic considerations presented earlier. These must be understood by the worker if the process is to be helpful. The first case is about a child with a host of physical symptoms which, we found, sprang from an underlying emotional disturbance. The second is about a child found to be severely retarded mentally whose parents had previously protested her normalcy despite a variety of diagnoses to the contrary.

CASE ONE

Billy C, a 9-year-old boy, was referred by a neurologist for study. The neurologist had seen the boy for possible psychomotor epilepsy but clinical findings were negative. The boy had been seen by 56 doctors, had been in 4 hospitals and in 2 institutions, and had been followed in clinics. There were repeated complaints of sore gums, sore throat, sore ears, headaches, sleep difficulties, temper tantrums, bedwetting, soiling, tearing of the eyes, pain and bloating of the stomach, refusal to go to school and, more recently, "spells" which had been diagnosed as psychomotor epilepsy.

The parents were confused, fearful and discouraged about their son. They were sure that he had epilepsy, a brain tumor and leukemia. For years they had feared Billy would die. They excused their lax and ineffective discipline on the basis of their fears saying, "We are afraid to upset him. We know he's sick. It's better to do nothing than to possibly kill him." Angry with doctors and hospitals, they said, "They give us the run around and don't tell us the truth. They take our money, though." The medical expenses had mounted rapidly and indebtedness was now at about $8,000. The father was forced to work at extra jobs and his income was such that he was not

eligible for public assistance. Neither parent evidenced insight into the why of the boy's behavior. Review of voluminous medical reports showed no medical basis for the many complaints.

The present pattern was one of Billy's being sick each morning at school time. He had coughing spells or complained of sore throats, headaches or stomachaches. The parents could not understand the morning sicknesses because "Billy is a brilliant boy and loves his teacher and school work." During the day he had "spells" in which he ran wildly about the house. The mother was unable to stop him. On a couple of occasions Billy stopped long enough to talk his younger brother into joining him. The spells did not occur when the father was at home.

The decision in an intake conference was for the psychiatrist to meet regularly with the parents while Billy was being studied. The decision was on the basis of the parental confusion, the medical aspects and the feelings the parents had toward the medical profession.

The diagnostic process for Billy consisted of his being seen by the clinical psychologist in four sessions and by the psychiatrist in one formal interview and briefly on several other occasions. Psychological tests administered were the Stanford Binet (Form L, 1937), WISC performance tests, Draw-a-man and other drawings, Symonds picture test, Bender *gestalt* and Rorschach.

In the first contact with the parents the psychiatrist stayed within the content revealed in referral and in the intake interview. Billy complained of bloating of his stomach and was seen briefly by the psychiatrist, who could find nothing of physical significance. After this first clinic visit by child and parents, the psychiatrist and psychologist discussed their preliminary findings and feelings in a brief conference. The tentative feeling gained was that Billy was of dull normal intelligence, that he used his physical symptoms as a possible defense against facing failure in school, and that the parents were completely confused by the controlling behavior and hollow threats.

During the second contact with the parents the findings and impressions were used in helping the parents to a realistic appraisal of Billy. For example, the parents had claimed that Billy was brilliant. They were asked, "In what ways is Billy brilliant?" and "Does Billy seem to be quick in book learning or is he better with his hands?" The parents talked back and forth in response to the questions and the father finally said, "He's like me. I was always a good talker but I had a hard time learning from books. Like me, Billy is good with his hands. He can take things apart and put them together again. He is a big help around the house if he wants to be." Both parents went further in expressing their false hope that Billy would fulfill their own unfulfilled educational desires.

Similarly, the question of "sickness" was gone into. "How sick a boy is Billy?" "Do you think that his spells are epilepsy or that he has some hidden disease?" After considerable discussion shared by father, mother and psychiatrist, the father said, "Billy doesn't like to go to school. He has a hard time keeping up. He's gotten himself way behind. He knows how scared his mother is. All he has to do is cough or hold onto his belly and she puts him to bed and calls the doctor. I have told her and told her that there is nothing wrong with Billy, but she won't listen." The mother came back strongly, "I know there's nothing wrong with him, but if I try to force him to go to school or do some work he has one of his spells or fights me. I'm afraid he will hurt me, himself or his brother. He gets so wild, and he's getting big." She

paused. "You're a big help—never at home when I need you. And when you are there, all you do is sit around and read the paper. Can't you see that I need your help?"

Their recognition that Billy was "using" symptoms, that they had negative feelings in their relationship, and that the father had given up at home was gone into extensively.

After this second clinic visit a brief integrating conference was held. The psychologist revealed confirmation of dull normal intelligence. She had utilized the findings and the tentative feeling arrived at the week before. To her questions and comments Billy was able to bring out the why of his dislike for school, to express his feeling of a lack of unity in the home, and to admit to use of physical symptoms as an escape. The psychiatrist shared what had gone on with the parents. He brought out his feeling that the parents were making good use of the interview situation, that they were realistically facing the problem, and that despite a show of negative feelings there was a basically strong relationship between father and mother.

The third contact with the parents went further into discussion of the findings and into the ambivalent feelings in the relationship between father and mother. They vented their terrifically negative feelings toward doctors. The fears of death dated to the boy's infancy. He had had "bloody flux" and pneumonia. He was expected to die and the parents were told that if he should live he would always be weak and "not quite right." Billy later had glandular enlargements and an abnormal blood picture. The boy was said to have leukemia. The parents had a friend who died of this. Now, with the spells, they were told that the boy had epilepsy with this possibly being caused by "something going on in his brain." The parents projected full blame for their confusion onto doctors and hospitals.

The psychiatrist pointed out that doctors were partially to blame, but that the parents themselves had a part in adding confusion to their confusion: "Not only have you confused yourselves through your lack of confidence in doctors and your running around, but you have certainly confused and very possibly angered doctors." The parents discussed this and the father summed up the discussion by saying, "We have made lots of doctors mad at us and they were right. We didn't give them a chance. I guess we just lost our heads."

Third contact with the psychologist more openly revealed the pattern of escape from failure. When faced with difficult material Billy began to cry and complained that his head ached, his stomach felt funny, and that the watering of his eyes made it impossible for him to see the work. The psychologist faced Billy with what was going on and the boy was soon applying himself to the tests. In discussing his spells he brought out, "I don't have the spells when I don't need them." To inquiry he enlarged on this by saying that at times the physical symptoms were not enough to gain his end; he therefore resorted to spells which "scare mother." He said that he didn't have the spells when his father was at home—"he would lick me."

Again a brief conference was held to integrate the findings.

The fourth session with the parents went more deeply into the breakdown in the parental relationship and their ambivalent relationships with Billy, and the findings of the psychologist were utilized in helping the parents to a realistic picture of their son.

In the fourth session with the psychologist Billy revealed full awareness of his use of physical symptoms and said that already he did not have so strong a need for these.

His mother did not scare so easily and she was now disciplining him for his misbehavior. Also, he was now going to school. The revelations tied in with the personality tests, which showed a pattern of immaturity and of reaction to upset in his milieu.

The clinical impression of the psychiatrist very closely approximated the findings of the psychologist.

A staff evaluation conference was held to integrate the total findings and to set forth recommendations. It was felt that the parents should be seen in another interview or two and that this case should be carefully followed up. The family physician and the school should be helped to understand the problem. It was felt that the further work with the parents would solve the problem and that Billy was not disturbed to such a degree as to require treatment.

The next meeting with the parents was a summation interview in which they were helped to bring out their full understandings of Billy and the part their parental anxieties played in his symptomatic picture. A full interpretation of our findings was then given. The parents expressed great relief and the feeling that for the first time the boy had really been studied and that they had been given true findings. They also felt they had profited by sharing and gaining an understanding of their anxieties, fears, confusions and resentful feelings. The parents were helped to arrive at recommendations.

The findings were shared with the school, the neurologist and the family doctor. The school welcomed the findings as fitting in with a realistic picture of the boy as they saw him.

The parents were met with on several occasions for a continuation of the process. Three months after closing the case the father reported that the mother and a new baby were doing well. Billy had had no symptoms for two months, was attending school regularly, was a far happier boy and was responding well to parental leadership and discipline. The father, "now able to think," had worked out plans for financing his debts. With this he was able to ease up on work and spend more time at home with the family. Subsequent follow-ups indicate that Billy is progressing as expected in school. At home "he is no angel, but he is like most boys of his age."

CASE TWO

Barbara S, an 8-year-old white girl, was referred by a pediatrician, who stated that the father and mother had a serious problem with the girl and with their own relationship. The father, a physician newly arrived in Buffalo, wanted the girl placed in a public school. He had run into some "red tape" because of some medical reports he presented. The school wanted further data on the girl. The pediatrician learned that the girl had been studied for possible deafness, brain damage, mental retardation, aphasia, speech difficulties and endocrine disturbance, and for possible emotional disturbance. The parents argued and were very contradictory in what they brought out.

The medical reports were reviewed before the parents were seen. At no point had an integration of the reports been made. The parents had gone to many outstanding clinics in the eastern part of the United States. The psychiatrist was assigned to meet with the parents because of the complexity of the medical reports and findings and because the father, himself a physician, would bring in a great deal of medical material.

The intake interview started with a lengthy review of the medical data. The

parents were very critical of diagnosticians, who had given them a wide variety of diagnoses—that is, that Barbara was deaf, mentally retarded, brain damaged, possibly autistic and possibly just emotionally disturbed. They called up evidence to explode each diagnosis and expressed the feeling that the girl was normal. The father in particular used medical textbook pictures of syndromes and went further in similar vein in postulating what might be wrong with the girl. He spoke of how her coordination was poor at times, of how she tended to pull away from people, and of her being a slow learner and possibly mentally retarded. As his own contradictions and confused thinking were pointed out, the father waxed eloquent in his damning of diagnosticians. He felt that the truth had been withheld from him because he was a physician. The suggestion was made that the intellectualizing, the contradictions and the verbal striking out were defenses against his own insecurities and that his attitude shaped how others reacted to him. The father protested and again projected the blame onto others.

Allowance was made for placing some of the blame on others, but he was told, "You have a definite part in reinforcing your own insecurities. It is not that you are to blame —you have tried your darnedest to do what you felt was right for Barbara. You have made many personal sacrifices in your 'shopping around' with Barbara. However, your well-meant efforts have backfired and helped to make you and Mrs. S more insecure, and Barbara has reacted to your confusion. If you (Dr. and Mrs. S) and Barbara are to be helped you will have to face the part you have played in the mix-up." The parents agreed that this was correct, and furthermore felt they had no idea what they were really seeking in their running around.

Both parents became less defensive and began realistically to consider what was needed. The mother brought out that no diagnostician had been able to get a valid picture of the girl because of her hyperactivity and distractibility, her clinging to her mother and her uncooperativeness. After one interview each diagnostician had given up. The parents wanted to see if we would be able to study the child and get some concrete findings which could be shared with them. They elected to wait until completion of the studies before again coming together.

The diagnostic study consisted of three sessions with the clinical psychologist and two with the psychiatrist. Our findings indicated that the diagnosis would be incomplete without further study. Barbara was therefore referred elsewhere for a general physical examination and a complete neurological study.

Barbara was noted to have stigmata suggestive of mental retardation and neurological impairment. Facies were "blank," there was occipital flattening without compensatory bossing, and there was poor coordination in the use of arms and legs. Study revealed the girl to be severely retarded developmentally. Head measurement indicated microcephaly. No localizing neurological lesion was found. The hearing problem was one of lack of comprehension. The poor speech and coordination resulted from the severe mental and developmental retardation. She was also seen as an anxious little child.

Barbara clung to her mother tenaciously. Mrs. S was in the psychologist's office during the first session. It was virtually impossible to test the child. Barbara did not seem frightened but was felt to be a very controling child. The mother was insecure and reluctant to leave her. Barbara had learned to take advantage of the mother's inability to function effectively under such

circumstances. The brief conference following the session focused on the need to effect a separation.

The second session started as did the first. However, the clinical psychologist told the mother what we felt was going on. After the discussion the mother reluctantly left, but stayed close to the office. Barbara put up a storm, but quickly quieted and began to cooperate in testing when she realized that she was not in control of the situation. A similar pattern followed in the third contact with the psychologist and in the sessions with the psychiatrist, the neurologist and encephalographer. Our knowledge of how to effectuate the separation was transmitted to the others and they were able to study the child with relative ease. Thus an adequate study of Barbara was made.

After each of the sessions the psychiatrist met briefly with the mother to set up the next appointment and to tell her of the findings. Also, the psychiatrist and psychologist met in brief conferences to integrate the process and share thinking.

An evaluation conference was held to integrate findings and arrive at recommendations. The neurologist and encephalographer participated. It was felt that the girl would quickly quiet down if the parents could be helped to accept the findings and go along with the recommendation that she go to a school for severely mentally retarded children.

The clinical psychologist and the psychiatrist met with the parents in the summation interview. The parents were very anxious and the father in a tentative way reached out for discussion of the weather. His wife jumped at this. Recognition was given to the why of the anxiety. The father opened by stating that he was frequently misunderstood by other doctors. He felt he tended to give the impression that he knew more than they did. This he felt angered them. The suggestion was made that the father was afraid he would scare us off and in doing so would not get the true findings and would be forced to "shop" further. He and his wife were told that we were aware of their knowledge of Barbara and that it would not be far different from our findings. We assured them that we would be open and honest and requested that they raise questions if they did not understand points being made.

The parents were then asked for their opinion of Barbara. The father said he felt her to be like a 3½- to 4½-year-old. However, she was able to do a few things at her chronological age. After further discussion between father and mother they arrived at a mental age of 3½. Our finding that Barbara had a mental age of 3 years 9 months was brought out. With this there was a lengthy and intense discussion of intelligence measurements. The clinical psychologist was able to spell out what intelligence tests measure in comparison to what the parents were relating from direct observation of the girl. Also, the psychologist was able to get across the concept of a range of functioning. Barbara evidenced a potential of functioning, but in actuality was functioning at a somewhat lower level. The "turning of a deaf ear," which led others to believe that Barbara was deaf, was due to the girl's lack of comprehension of many things. She could converse adequately at a very simple level. The "turning of a deaf ear" was also seen as a way that Barbara escaped situations which frustrated and overwhelmed her.

The question was now raised as to why Barbara was the way she was. The parents felt that something happened that they could have prevented. Their guilt feelings were discussed. It was then pointed out that we felt this problem to be entirely on a developmental basis—that Barbara had

been different since the union of the egg and the sperm. For confirmation of this the uncomplicated mental retardation and the microcephaly were cited. The normal pregnancy, birth and postnatal periods were tied in. The parents readily accepted this as the logical possibility. The poor coordination and the speech difficulty were seen as a result of the severe developmental retardation.

Mrs. S now said, "There is a lot Barbara can do if she wants to. She starts to do something and then all of a sudden goes away from it. Also, I can't get her to do things on her own. She won't let me out of her sight." This led to further discussion of limitations, of natural findings with this degree of impairment, and of emotional problems. We pointed up the separation problem and the basis for it, and discussed the emotional problems in the parental relationship and in the relationships with Barbara. The parents brought out frankly that they had had need for the girl to function as an 8-year-old, saying "We have tried to kid ourselves and others that she is normal."

Dr. and Mrs. S asked for practical suggestions about discipline for Barbara and her siblings. Once they realized that we could not tell them specifically what to do, they felt they could work together on this now that they understood Barbara and the problem. Dr. S recognized that all of the children had resented the constant attention demanded and received by Barbara. Now, with their feet on the ground, things would be different.

Recommendations were discussed in closing the interview. The parents brought out the need for specialized schooling for Barbara and decided to enroll her in a local center. They spoke of the severe handicap and of the limited help she could receive. They would now start saving their money for education for the other children and for some pleasures for the family and themselves. They did not feel a need to return for further discussion, but wanted to know that they could come to talk with us from time to time. The door was left open to them. Their changed attitudes, their ability to face the problem squarely, and their realistic picture of Barbara gave us the feeling that the "shopping around" was at an end.

A conference and written report of findings brought about placement in a special program. Barbara has been happy there for close to three years. There have been a number of contacts with the school and Barbara has been reevaluated with the earlier findings confirmed. The parents have been seen in several follow-up interviews and there have also been a number of telephone contacts. Things have gone well for Barbara and the family. It is of interest that the parents have to a degree sublimated disturbed feelings in P.T.A. activities and in becoming involved in community mental health efforts.

DISCUSSION AND CONCLUSIONS

The two cases presented give a picture of overall design of diagnostic study. It can be seen that there is no stereotypy. There are as many variations as there are cases. Flexibility is needed if the family problem is to be met. The first case illustrates our use of graduated interpretation of findings, the second our way of handling the presentation of findings in a summation interview. The cases indicate the breadth of application of the process for diagnostic situations. This encompasses physical or emotional problems or a combination of the two. The cases also illustrate the effective work that a clinic can do in families of varied educational, social and intellectual backgrounds.

The basic parental problem in the cases is seen to be the same—anxious, confused parents who were on the defensive and on the run. The first family had limitations in the intellectual, social and financial spheres. The second family had none of these. Because of limitations the first family "shopped" locally, while the other "shopped" on a national scale. Both were able to profit with equal effectiveness and solved their problems. The first situation was solved in realistic and practical terms. The second, having a continuing problem of a severely impaired child, went beyond handling mixed feelings to becoming closely identified with community efforts.

All of the foregoing adds up to our conviction that there is more to satisfactory diagnosis than the findings of a specific condition in the child. The most important aspects of the process described are these:

1. The parents are directly and actively involved in the process. The worker shares findings with the parents and helps them consider every aspect of the child's functioning. The goal is to help in the total problem presented rather than to focus on the narrower aspect of the diagnosis itself.

2. A dynamic approach helps the parents to understand their individual feeling of inadequacy, their confusions, anxieties and guilt feelings. Parents gain insights into their relationships with each other and with the child. They gain a full understanding of the diagnostic findings and are helped to an emotional acceptance of the impaired child. The summing-up interview particularly helps the parents to an integration and crystallization of the complete findings. Parents rediscover and rebuild faith in themselves. Thus they are helped to assume normal parental roles and to function more effectively within the family and with people generally.

3. The total process meets the needs of parents as expressed through their complaints about prior studies. Findings are presented completely and honestly with no hollow reassurances given. Instead of giving direct advice, we help the parents to make their own decisions and recommendations. The parents are talked with in language they can comprehend.

4. To achieve these results, the worker and diagnosticians must have a good understanding of the process and the dynamics in the case. This is effected through supervision and through staff conferences in which the consultants, if active, participate if at all possible. The team members thereby gain in security and in their positive and accepting attitudes towards the confused and upset parents. Thus, for example, negative and antagonistic feelings expressed by the parents can be accepted, securely handled and placed in proper perspective.

5. It is therefore evident that the team approach, which implies constant integration of the case, is necessary for a successful outcome. For this to work, there must be good understanding and mutual acceptance of the skills of the various disciplines.

The process is time-consuming and costly, but our conviction of its worth has led us to adopt it as a valid approach and to gear our clinic practices to its use. Through our periodic re-evaluations—repeat diagnostic studies—and through our follow-up contacts, we find that the very high percentage of successes completely justifies our effort. Not only are the parents stopped in their running and "shopping," but both they and the child are therapeutically helped through diagnosis.

CELIA BENNEY
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Treatment of the ambulatory schizophrenic in a rehabilitation center

Mental hospitals have for many years had the relatively exclusive responsibility for helping their discharged patients adapt or readapt to their families, their work and their communities. It has long been recognized that many patients could not sustain or improve the level of adjustment achieved through hospitalization without substantial help outside. Yet the limited resources of most hospitals and the dearth of community facilities to meet even the most glaring needs made this, at best, a frustrating if not hopeless task. Even now comprehensive rehabilitation programs for patients discharged from mental hospitals are hardly overwhelming in number and scope. However, the stimulus of public support through the Office of Vocational Rehabilitation and community mental health boards and the increased pressures for services, created by the effects of chemotherapy, have spurred experimentation in utilizing and readapting existing resources as well as devising new ones to cope with the problems of the mentally ill.

In this paper we shall discuss the experience of the Altro Health and Rehabilitation Service in extending its facilities to schizophrenic patients discharged from hospitals. For those unfamiliar with the background and services of the agency, a brief description of structure and program will offer a frame of reference for our comments on some aspects of casework treatment in this setting.

The Altro Health and Rehabilitation Service is a rehabilitation center which by definition offers "an integrated program of medical, psychological, social and vocational services" (1). At Altro this is provided

Mrs. Benney is director of social services and assistant director of rehabilitation, Miss Waltzer casework supervisor for Altro Health and Rehabilitation Service in New York City. They wish to acknowledge with deep appreciation the conceptual and technical contributions of Dr. Leopold Bellak, Altro's chief psychiatric consultant, to the practice described in this paper, which was presented in May 1957 at the National Conference of Jewish Communal Services.

by a professional team which consists of psychiatrists,[1] a consultant psychologist, social workers, a full-time vocational counselor who is a member of the staff, teachers and nurses. Basic to the program is a philosophy of the agency's responsibility to provide directly and aggressively, and for as long as is necessary, the multiple professional and concrete services needed to enable the handicapped person attain an improved level of adjustment.

A basic tool and the fulcrum of our services is the Altro Workshop, a large garment factory which provides a real work milieu in which the handicapped person can experience normal industrial demands in terms of production and interpersonal relationships. In addition to training in garment operation, there are two classrooms—one for clerical training and the other for the fundamentals of bench mechanics. The supervisory production personnel are all laymen.

In relation to the worshops, the admission of psychiatric patients posed many questions:

1. What would be the effect of this group on the rest of the patient population—tuberculous and cardiac?

2. What effect, if any, would the other patients have on the psychiatric group, particularly in terms of somatization of symptoms?

3. How would the lay personnel (supervisory, foreman) react?

4. What orientation would they need?

5. What adaptation, if any, to structure should be made?

6. How many could be absorbed for maximum therapeutic efficiency?

It is not our purpose to give detailed answers here (and even if it were, they are not completely available). Nevertheless, it is important to state that it was decided to retain the essential structure and atmosphere of the shop as an industrial establishment—with flexibility and protection but undiluted by occupational therapy and recreational facilities beyond the usual ones in a good urban plant. Certainly the staff was asked to be sensitive to the reactions of the psychiatric patients, but this did not mean chaotic permissiveness of the old progressive school type. Personnel, foreman and teachers were to represent reality—albeit a flexible, benign reality—in which people, including schizophrenics, were expected to behave as workers or students. When the teacher in the classroom found that one of the patients had been writing on the wall she made the very appropriate request that he wash the words off. On the other hand, when a newly admitted paranoid boy had to hide from visitors going through the shop, this was respected until he became a little more secure and could accept it as routine.

It has also been necessary to be concerned with the distribution of assignments of psychiatric patients, since they have tended to overweigh some of the departments, particularly clerical training, shipping and finishing. Finishing offers an opportunity for simple routine work, and shipping provides a physical outlet for tension. What can and has happened, however, is that too many slow-moving people, preoccupied with fantasies, can begin to set the tone of a department and depress the productive

[1] Theoretically, responsibility for psychiatric treatment rests with the referring hospital or clinic. In practice, this service is often quite limited and the agency has on occasion resorted to purchasing private psychiatric treatment. Consultant psychiatrists at Altro Health and Rehabilitation Service are available for the screening of applicants and emergency treatment, as well as for consultation directed toward diagnostic and treatment formulations.

pace of even the mainstays of the department, thus destroying a basic therapeutic element.

In the light of all these considerations, plus the fact that we set our sights at vocational as well as emotional and social rehabilitation, one might wonder at the nature of our psychiatric population. Selectivity was certainly present, but not in the usual sense. Initially, in 1953, our services were limited to a select group of patients discharged from Hillside Hospital, a voluntary psychiatric hospital. Shortly thereafter they were extended to an even more select group — schizophrenics discharged from state hospitals. Emphasis has been placed on selection in an attempt to highlight the fact that the psychiatric population at Altro does not represent the usual level of handicap of discharged patients. Research studies have indicated that in our recent era of full employment only 15% to 20% of the patients discharged from mental hospitals were unable to obtain employment (2, 3). It is, then, the group of the most severely handicapped patients who are referred to rehabilitation agencies. The wisdom and effectiveness of this type of selection is, of course, highly questionable, and it is our hope that more of the people who may be able to obtain jobs but are not really ready for them may be spared the trauma of repetitive failure by early recognition of their needs.

Almost by accident one of these came to our attention (through our research project) when she was just about at the breaking point. This very intelligent, capable, young schizophrenic woman was involved in an aggressive sales job which was touching off intense anxiety related to her fears of aggression and competition. A transition experience in the workshop, with treatment of her manifold problems, ultimately enabled her to find more satisfying and less tension-provoking work. This, however, represents the exception. In general, it is those who cannot get employment or have already failed several times and are extremely ambivalent about work who are referred.

One more word on the nature of the psychiatric group at Altro. The diagnostic label of schizophrenia has come to represent considerable variation in degree of pathological severity. The psychoneurotic of one hospital may be much closer symptomatically to the schizophrenic of another than the schizophrenic of one is to the schizophrenic of a third. Some of the factors involved are the voluntary nature of admission to some private hospitals, the pension implications of Veterans Administration hospitals, and the quantity and quality of psychiatric service.

Some common denominators, of course, do exist among the schizophrenic patients. Anxious, ambivalent, withdrawn, they are eternally caught in conflict between their infantile emotional needs and the expectations of society. Beginning with relatively weak egos (perhaps at times on a constitutional basis) and battered by rejection by significant people, they are forever seeking the unattainable. Their needs, frequently on every level and in every sphere, are great.

How do we relate to them? In our setting there are three primary elements constantly juxtaposed and interwoven which profoundly affect treatment: the therapeutic work milieu, the professional team services, and the availability of a wide range of concrete services. Operating on all fronts, we are able to reshuffle the cards in limitless variations in an attempt to find the most effective combination for a given situation.

Our primary focus in this paper is on the caseworker's part in the treatment of the ambulatory schizophrenic. In our set-

ting it is the caseworker who carries the continuous and integrative responsibility for staying with or being available to help the lonely, confused and sometimes openly psychotic patient move into the workshop, use its professional and non-professional resources and move on, hopefully, to a better adjustment. It is anticipated that some will come back to the shop, for shorter or longer periods, in what Bertram J. Black has called the pendulum effect (4). More, however, will need continued or intermittent service for an indefinite period of time to remain functioning in the community. Great demands are placed on the caseworker. Sometimes it is as if he were in the position of a tugboat giving the heavily laden ship a start and then permitting it to go on its own steam, but being there again to lead it into port or help it navigate when the straits get narrow.

In describing our treatment techniques and methods we shall highlight some of the subjective factors which are involved in the caseworker's handling of the external-internal factors in the daily life of the patients at Altro. These qualities are, of course, not fundamentally different in kind from those basic to good casework, but the emphasis is perhaps a little different. Most important therapeutically are:

1. The capacity to respond to dependency manifested frequently by insatiable, unrealistic demands, while assuming responsibility for helping the ill person move towards independence. Although, in Esther Glickman's words (5), "the giving of gratification and security can prove an endless task and make for poor therapeutic results," one must be available when anxiety becomes intense, when panic begins to appear, when reality becomes difficult because of loss of a job or a dozen other crises. Results are rarely dramatic and it takes patience over the long pull to really sustain equilibrium and/or modify adaptive patterns. Daily repetitive, perseverative complaints or symptoms, often physical, may seem impenetrable for months. During these periods the worker may find the patient day after day in the office when she gets there and may need to spend far longer than the 50-minute hour to help him take the next step.

One young woman who came in at 8:30 every day for about two weeks, with her lunch basket, complained of severe palpitations and dizziness. Although it was recognized with her that her physical symptoms were psychogenic in origin, she was given the reassurance of a cursory physical examination by our clinic physician and was permitted to remain in the waiting room for a good part of the day. At the same time in her daily interviews with the worker there was active interpretation of her hostility and passivity in relation to her current difficulties in the clerical course, touched off and intensified by the prospect of completing her training. Even after she was able to return to the classroom she required very close contact to eventually be able to move forward. Parenthetically, it might be said she has now been working for several years and has been able to assume the responsibilities of marriage.

2. The patience required must be matched by an awareness of the subjective operations and needs of the worker and sensitivity to the way these are used by the patients. Anyone who has worked with psychiatric patients is aware of the almost uncanny ability of the psychotic to sense and respond to the worker's fears and conflicts. When this perceptiveness is used by the ill person to control the treatment situation, it is obviously not very helpful.

For example, the young woman who found that she could use her dramatic

threats of suicide to control and manipulate the worker did so until the worker became aware of her own reaction and involvements and was able to handle them. In this situation the patient had been known to the agency for some years previously as a tuberculous client, and in her history were several threats and attempts at suicide. On one occasion she even went to the Empire State Building with the intent of jumping off but found the cost of admission was too high. Nevertheless, although there was always the possibility that she might accidentally make it, our psychiatrist felt the risk was minimal. The threats of suicide ceased one day when the patient, leaving the room after an interview in which she denied all emotional problems, said she would probably not be alive by the time of the next interview; and the worker had reached the point where she could respond by helping the patient recognize she was using her threat to avoid looking at her problems.

On the other hand, even where control is involved and has been used it cannot become an excuse for lack of sensitivity and understanding of underlying motivation. For example, Mr. F, who is known to have an extremely low frustration tolerance and, like so many others, an insatiable need for attention, had created quite a scene following an occasion when the psychiatrist had to cut his hour to a half hour. This was handled and worked on in ensuing sessions. Several weeks later when the psychiatrist was out ill on Monday, the patient made a supreme effort to handle his disappointment and was willing to wait a full week for another appointment. However, when his caseworker was ill the following day, he called the supervisor and said that he was through with caseworkers and psychiatrists. Sensing his guilt over his aggressive feelings, she was able to offer the necessary reassurrance. In this instance it was directly reinforced by the caseworker's phoning him at the workshop and letting him know that he had not destroyed her.

3. A third quality which had until recently been notable for its absence is realistic therapeutic optimism. When I [2] worked on my master's thesis, a follow-up study of schizophrenics, many years ago, I was fortunate to have an *avant-garde* clinical director of a state hospital as adviser. He was interested in research on the thought processes of schizophrenics and was undergoing psychoanalytic training. Yet every time I found a patient who seemed to be making a particularly good adjustment, he screened the record carefully to see whether the diagnosis stood up. The early literature on schizophrenia made unfavorable prognosis a diagnostic criterion. So it is hardly surprising that the pessimism persists. Also, any reactivating illness tends to try the hopefulness of professional workers who keep investing. Furthermore, limited resources—therapeutic and concrete—certainly add to the discouragement. Yet without optimism it is difficult to see how anything can be achieved. This optimism is not, of course, the optimism of Coué; it is based on the conviction that people have some drive toward health, however weak this may appear; that the psychotic symptoms are defenses; and that energy can be mobilized and channelized provided the professional and environmental resources are available. Incidentally, it has been our observation that in a multi-disciplined setting the optimism of one member of the team can frequently influence the other.

When Mrs. D, who had been working productively and quietly at the workshop for some months, suddenly went into a

[2] Celia Benney.

state of catatonic excitement, began to hear voices again and crack windows, the episode might understandably have resulted in hospitalization. However, with the worker willing to play the good mother and spend long hours with her (including evening hours), with emergency psychiatric consultation and treatment available, with the help of chemotherapy, and with the funds to obtain temporary homemaker care, she was back at work within two weeks. In this instance, a study of the precipitating factors—heightened sexual conflict touched off by the presence of painters in the home—made it possible to begin to deal with a part of the problem and rechannelize the energy into work.

Obviously, the capacity to ride through such episodes reenforces the ego and reduces some of the panic at the reappearance of symptoms, permitting the patient to seek help earlier. When Mrs. R, who is a paranoid schizophrenic, begins to be depressed and have ideas of reference, she is no longer afraid to approach the agency for help before the symptoms become full-blown. Initially she would wait until she developed severe depression, tremendous hostility and open paranoid delusions. The episodes are decreasing in frequency and, whereas at first each was accompanied by loss of job, she can now be sustained even while on the job.

4. Although there are certainly many other important qualities, the last we shall mention is perhaps one of the chief characteristics of our casework approach, namely, the willingness to take risks, to be active and even authoritative. The casework literature abounds with "don'ts" in casework with schizophrenics: don't interpret, don't uncover, don't let the transference develop too intensely, don't push, don't touch defenses. Implied even in the positive injunctions are more of the same: be supportive, be permissive, go slowly, be reassuring, help repress, be giving. Certainly most, if not all, of those do's and don'ts are valid in treatment. Nevertheless, it is our belief that the caseworker, while not pretending or aiming at personality reorganization, can deviate from the do's and don'ts and occasionally use more direct treatment techniques. Our experience would lead us to raise questions about such definitive statements as "The client's defenses are accepted; no attempt is made by the caseworker to change them in any way; no interpretation of his mechanisms is offered to the client" (6). It is our feeling that we would never get our patients to move in or out of the workshop if we made no attempt to break into the defenses of isolation or to interpret dependency problems.

For example, Mrs. C, a 48-year-old woman with a history of four hospitalizations, had great difficulty in accepting the rehabilitation service of the agency at the time of referral. She had already failed several times in private employment following her discharge from the hospital. It was not until she could see that her resistance to rehabilitation was directly related to some of the elements in her sadomasochistic relationship with her husband that she could begin to participate in the rehabilitation process. Working, to her, meant an acceptance of the reality of separation from him, relinquishing the gratifications of her dependency on him, and recognizing that he would continue to be rejecting and punishing. The worker actively confronted her with some of the mechanisms involved. This woman is now successfully rehabilitated, working consistently and productively and has even been able to reject her husband's invitation to return to the home. We have also been somewhat less than cautious in relation to transference problems. One ap-

proach noted in the literature is represented as follows: "Once the current anxiety has been resolved and supportive help has enabled the patient to make some forward steps in his job, then termination is broached (by the caseworker) before transference problems have become so overwhelming as to be unmanageable for both the therapist and the patient" (7). This was in an article which dealt with recurrent crises situations and their handling as crises. In our own experience we must admit that we have had some anxious moments concerning transference developments, but have looked for and used devices which helped dilute them, so that the positive elements remained and could be used constructively.

In our setting we do have some built-in safeguards. For one thing, the patient has an opportunity for positive identification with a number of people with whom he is involved for many hours during the day. Furthermore, the team approach offers opportunity for the sharing of cases, which can help dilute transference, particularly when one worker is female and the other is male. We have in different situations shared cases in a variety of ways: social worker-psychiatrist, social worker-vocational counselor, and even two social workers.

Another extremely important factor is that of the two levels of treatment which exist concurrently. A split-level approach is not new and has been tried in a variety of treatment situations. For example, the simultaneous use of play therapy and verbal treatment on an adult level has been described. At Altro the adult world is represented by the workshop. On that level the patient is expected, in spite of his difficulties, to perform as an adult in a permissive, flexible environment. Although the environment is related to the patient's adult strivings, it is not as overwhelming or as terrifying as the real world. The expectation that he has the capacity to function on this level seems to reduce some of the guilt and feelings of worthlessness which are related to his dependency needs and libidinal and aggressive impulses. Meeting the infantile needs alone frequently only serves to reinforce feelings of worthlessness with increased aggression and guilt. On the other hand, it appears somewhat easier for him to risk more adult performance when he knows that there will be some opportunity in the casework relationship for expression of his more infantile needs. Thus the worker and the patient have some degree of protection, permitting some greater freedom in dealing with the patient's emotional problems more directly. Ego-strength, of course, must be constantly assessed.

In the case of Mr. B, a very bright young man with a history of dementia praecox, paranoid type, and two hospitalizations, the caseworker permitted the development of a strong, positive sexualized transference to the point where the negative aspects were beginning to emerge, expressed by his fear that women would control him. He was seen briefly by the agency's psychiatrist who dealt somewhat directly with his fears around his passivity and success neurosis. Mr. B then seemed to be less threatened in his relationship with the caseworker, as he was able to identify with the psychiatrist as the strong, accepting, warm father-person. In addition, he was helped to maintain his equilibrium through frequent interviews with the vocational counselor, who was actively involved in relating to his vocational goals. He continued his relationship with the worker for some time after his discharge from the workshop, focusing on his anxiety around his adjustment to his new job. She used the relationship to help him move into private psychiatric treatment, which

had been particularly threatening to him because his previous experience had led him to equate psychotherapy with breakdown. Even after he began treatment with the psychiatrist he continued to see the caseworker for approximately three months. When he told her that because of his great attachment to her it was impossible for him to become interested in other women, she helped him see that he was using his relationship with her to perpetuate his basic problem. He was actively encouraged to discuss his attitude towards the worker with his doctor and was able to work through his transference problem so that the termination of the relationship was not handled abruptly. He has now been in treatment for over a year and his therapist reports that he is using it effectively and has made considerable progress, both on his job and in his social relationships.

To conclude: We have tried to present some aspects of our experience in the treatment of schizophrenics at Altro, both subjectively from the point of view of the caseworker and objectively in terms of the setting. Although it is difficult to set criteria for success, we can say that on the minimal level of keeping patients out of hospitals, 80% of our first 25 graduates are successful. There remain, of course, many areas in which treatment techniques and services need to be developed. Nevertheless, our experience to date does seem to demonstrate rewards that can be expected if the inner and outer resources of the patient, family, professional personnel and community can be mobilized towards the rehabilitation of the mentally ill.

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Prevention and cure

Our hopes of preventing mental illness by mental health education and child guidance clinics have been disappointed, and there is no convincing evidence that anyone has ever been kept out of the state hospital by such measures. Similarly, although we have made respectable advances in symptomatic treatment of psychosis, it is highly doubtful whether the primary schizophrenic process is ever "cured."—*Robert C. Hunt, M.D.*, Hudson River State Hospital, Poughkeepsie, N. Y.

BARTHOLOMEW D. WALL

Rapport: An outmoded concept

In some branches of the behavioral sciences the organization of theory into an integrated whole is being delayed by the use of certain outmoded concepts. In the field of guidance and counseling the phenomenon of *rapport* constitutes such a concept. Whereas writers in related fields—clinical psychology, psychiatry, psychoanalysis and case work—have taken the long view of interpersonal relationships transpiring throughout the entire counseling contact, leaders in guidance and counseling have espoused what might be termed a segmented view of the counseling process.

Some writers in the field of guidance speak of *rapport* as though it were a separate step in the total guidance process. Jones has said in outlining the counseling procedure:

"Establish rapport. Feelings of friendliness, security and mutual confidence are essential and should be established before the serious work of the interview begins." [1]

With reference to the same general point, Robinson has stated:

"Friendly discussion or small talk often occurs at the start of a conference . . .

". . . Realizing the true nature of small talk in the beginning of a conference, the counselor can participate in it naturally and easily and then turn to the client's problems when both of them are seated and have attained an initial stage of rapport and understanding." [2]

Still other writers regard *rapport* as being no more significant than "getting acquainted" in any other type of relationship situation.

Williamson and Hahn have stated:

"Establishing rapport is very much the same problem as becoming intimately acquainted with persons in other relationships of a face-to-face nature.[3]

In such statements *rapport* seems to be defined as a doorway through which both client and counselor must pass simultaneously to attain their ultimate goals. Such statements appear also to imply that *rapport* is a rather conclusive first step so far as

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[1] Arthur J. Jones, *Principles of Guidance*, New York, McGraw-Hill Book Co., 1945, 274.

[2] Francis P. Robinson, *Principles and Procedures in Student Counseling*, New York, Harper & Brothers, 1950, 149.

[3] E. G. Williamson and M. E. Hahn, *Introduction to High School Counseling*, New York, McGraw-Hill Book Co., 1940, 203.

the outcomes of guidance are concerned, as though the type of *rapport* attained predetermined subsequent action. This point of view would seem to be incompatible with the idea that relationships can be and usually are developed throughout the entire guidance contact, whether one or several interviews.

An example of the long-range view existing in related fields has to do with the mechanism of transference and with a definition of guidance which emphasizes the interpersonal relationships existing throughout the entire guidance contact.

If one accepts the mechanism of transference as a real, functioning concept, one must see *rapport* as nothing more than a descriptive adjective limited to the superficial aspects of client-counselor relationships, especially with the transference process beginning immediately with the first contact and continuing through to the end of the relationship. Sterba, Lyndon and Katz have described transference as a repetition of previously conditioned attitudes toward a significant adult in later contacts with other significant adults.[4] The most significant adults in a person's life would appear to be his parents, and the establishment of attitudes toward them would appear to play a part in the attitudes, expectancies and feelings of a person in later contacts with other key figures.[5]

The working through of the transference by the client constitutes the backbone of the treatment relationship between the therapist and the client.[6] Fenichel has stated:

"The repetition of previously acquired attitudes toward the analyst is but one example of the most significant category of resistance, the handling of which is the core of analysis: the transference resistance." [7]

And again in a recapitulation of Freud's theories:

"By 'establishment of a transference neurosis' Freud meant that the repressed infantile instinctual conflicts find their representation in the feeling relations toward the analyst." [8]

Thus an awareness of transference would seem to motivate one toward an emphasis of the total counseling relationship rather than toward any artificially segmented part of the procedure.

Most dictionaries define *rapport* as harmony, and *process* as forward movement or progress. However, when one attempts to define progress operationally one generally thinks of such on-going talents as the ability of the client to aspire to certain achievements through guidance and counseling, to assimilate certain knowledge, to make realistic decisions in keeping with that knowledge, and to initiate and sustain appropriate goal-directed action. It would appear only reasonable to include something about his ability to establish and to maintain effective interpersonal relationships, not only as an indication of progress in the interpersonal relationships of client and counselor but as an indication that the transference phenomenon had been facilitated.

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[4] Richard Sterba, Benjamin H. Lyndon and Anna Katz, *Transference in Case Work*, New York, Family Service Association of America, 1948, 16.

[5] For example, teachers, principals, counselors, policemen, supervisors on the job, etc. The attitudes expressed by the client toward the therapist are referred to as transference, and those of the therapist toward the client as counter-transference. Transference and counter-transference may be positive or negative depending upon the type of feelings expressed by the client or the therapist.

[6] It is not suggested here that the counselor administer therapy in the medical sense, but that he see the value of understanding such mechanisms as they function within his professional frame of reference.

[7] Otto Fenichel, *Psychoanalytic Theory of Neurosis*, New York, W. W. Norton and Company, 1945, 29.

[8] *Ibid.*, 559.

Well-known writers in the field of guidance seem to feel that the following benefits will derive from an acceptance of *rapport* as a first step in the guidance procedure:

1. It enables the counselor to start out with emphasis upon first relationships, "putting the best foot forward," so to speak.

2. It enables the client to relax amidst all his problems.

3. It facilitates the ventilation of problems and feelings by the client.

4. It puts the client and the counselor together or on the same plane in seeking solutions.

Yet the writer knows of no research supporting such expectancies by experts in guidance. In addition, separating the initial phase of the guidance procedure, conceptually, by giving it a name would seem to contain several weaknesses:

1. It would seem to enhance the odds in favor of an artificial relationship between the client and the counselor, where the counselor emphasized the creation of a friendly atmosphere.

2. In terms of item #1, the counselor might be inclined to do too much of the talking, with subsequent and unwarranted structuring of guidance process (that is, blocking the transference process).

3. It might conceivably incur anxiety in the client where inconsistency in counseling techniques and pacing adversely affected the client-counselor relationship.

4. It could conceivably result in later blocks where the client was seemingly encouraged to ventilate his problems too fully, thereby developing embarrassment and accompanying defensiveness.

It would seem better for persons who wish to function in the role of guidance to take the long view of the total counseling process rather than approach it segmentally for the following reasons:

1. Segmenting the counseling procedure, even nominally, cannot help but lead to the emphasis of one "part" over the other in some cases. For proper balance it would seem more reasonable to approach the guidance task, conceptually, with a wholistic view.

2. The total process view would seem to provide a better conceptual base for consistency in the use of techniques and in pacing.

3. The total process view would appear to facilitate acceptance and awareness of the mechanism of transference.

4. The total process view would appear to preclude any feeling of artificiality during first contacts.

5. The total process view would seem to reserve to the counselor some controls over the kinds of spontaneous outbursts which might later act to block the relationship.

In summary, the writer would like to state that the concept of *rapport* as put forth by some writers in the field of guidance seems to be misleading generally and that the theories out of which it emerged have been superseded by more pragmatic theories which emphasize the long-range or total process point of view. The counselor might more effectively concern himself with such total contact phenomenon as the mechanism of transference. It would seem that the best way to expedite the transference process would consist of dealing immediately with the problems which bring the client to the counselor in the first place, since they are of most interest and of most pressing concern to him.

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The rehabilitation and disposition of chronically hospitalized schizophrenic patients

This paper discusses a successful treatment program in the rehabilitation of the chronically hospitalized psychotic patient. The methods used at the Veterans Administration Hospital in Salt Lake City have resulted in an unusually high percentage of such patients leaving the hospital to make a satisfactory adjustment to community living. Five years ago the continued treatment section at this hospital was activated by the transfer *en masse* of 72 chronic psychotic patients from other VA hospitals. This group, which lends itself to easy statistical study, consisted of unusually difficult cases. They were all chronic severely ill patients who had been particularly resistant to all rehabilitation efforts prior to transfer.

The plan of this paper is to describe the program used with these patients and the results obtained and to follow with a discussion of the problems and philosophy which characterize this operation. It may appear that the program used is not unusual or necessarily different from that of other well staffed VA and state hospitals. The unusual results obtained, however, are thought to be a result of the underlying philosophy, which will be presented following the section on results.

THE POPULATION

The continued treatment section, now consisting of 128 beds, has been maintained near capacity since shortly after receiving the original 72 transferred patients. The transferred group became part of the section as a whole and all patients followed essentially the same treatment program. The median length of hospitalization of this "hard core" group of 72 patients was 7 years and 8 months at the time of their transfer to this hospital.

Dr. Ellsworth is a psychologist, Dr. Mead is chief of continued treatment service and Mr. Clayton is a psychiatric social worker in the Fort Douglas division of the VA Hospital at Salt Lake City.

THE PROGRAM

The continued treatment section of this hospital is characterized by an active and aggressive approach in attempting to rehabilitate chronically hospitalized patients. This section is composed of four 32-bed wards; a closed ward, a semi-open privileged ward, an open privileged ward and a research ward. The first three are designed as progressive steps, from the locked ward with supervised activities to the open ward with individual assignments. As the patient improves he is transferred to the next best ward where additional privileges and responsibilities are given him.

The closed ward activity program consists of a full day of occupational therapy, corrective therapy and supervised work activities along with various recreational programs. On the semi-open and open wards the patients are given limited privileges on the one and complete privileges on the other. In addition to group and individual work assignments, both of these wards have weekly meetings with the psychiatrist and other ward staff [1] in which all patients are encouraged to bring out their problems and discuss their goals. The completely open ward has, in addition, an active patient government program which encourages the patient to share in the responsibility of managing his life.

The experimental ward is used as a research ward where new methods of treatment are continuously evaluated. This ward contributes greatly in keeping the morale and enthusiasm of the personnel at a high level. Patients who have not responded to treatment on the other wards are placed on this ward where the expectation is that some of them will get better. In this setting many regressed patients have shown remarkable improvement.

In addition to nursing personnel, the building is staffed by one full-time psychiatrist, one resident in psychiatry, one clinical psychologist and two psychiatric social workers. The social workers spend most of their time working with families in planning for the veterans' return to the community.

RESULTS

At the time of a report one year ago to the VA Central Office 18 of the original 72 transferred chronic patients treated in the continued treatment section had been discharged. This represented a 25% discharge rate. When compared to the usual 5% (or less) discharge rate of chronic patients in state hospitals, this 25% figure appeared unusual.

Since the previous report, an additional percentage of this original group have left this hospital. Table 1 presents the results of this program as of December 31, 1956. Of these 72, 35 (49%) are currently out of the hospital.[2] Four patients who were placed on trial visit during the preceding four years have returned and are currently in the hospital. In addition, 8 other patients returned temporarily from trial visits and have been returned again to the community. Most of these are currently doing well and certainly cannot be regarded as "failures." Only 2 patients currently out of the hospital were placed in foster homes.

It must be emphasized that the release of the majority of these patients from the hospital represented real improvement; they were not simply relocated, unimproved, in the community. The mean hospital ad-

[1] A similar meeting was recently instituted on a more limited scale in the closed ward.

[2] Four patients were recently transferred from the continued treatment section. Three of the four were temporarily placed on the geriatric service before leaving the hospital.

TABLE 1

Results of treatment of chronic psychotic patients

DISPOSITION OF CASES	1953–56	1956–57	TOTAL
Total number of transferred patients treated in continued treatment section	72	72	72
Total number left hospital	20	19	39
Currently out of hospital	18 (25%)	17 (23.6%)	35 (48.6%)
Returned and still in hospital	2 (10%)	2 (10%)	4 (10%)

justment (3) rating of this group, shortly after arriving at this hospital, was at the fifty-third percentile. Just before they left the hospital (within six months) the mean was at the seventy-sixth percentile, representing a very significant increase in social adjustment. These scores were obtained routinely every six months for the entire continued treatment section and therefore do not necessarily represent the patient's adjustment at the time of discharge. Many patients improved within two months of discharge, which was often not reflected in the hospital adjustment score, since the rating was sometimes completed before improvement occurred.

PROBLEMS OF OPERATING A SUCCESSFUL CONTINUED TREATMENT PROGRAM

At least two problems seem worthy of special comment. Each of them is seen as being potentially capable of limiting the success of an aggressive program aimed at eventual rehabilitation and discharge.

The first of these is, of course, the maintaining of high morale among the personnel. At a recent ward meeting the entire population of the building was discussed. Of the 126 patients in the building, there were only 6 for whom no immediate treatment goal was set. The majority were viewed as in a period of transition with specific goals outlined for them. The staff has regarded each patient as capable of rehabilitation. Few, if any, patients were looked upon as hopeless. If they had not responded to date, something else was planned for them, perhaps on the research ward.

The second problem is that of accumulating a backlog of patients resistive to treatment. As more patients are discharged and replaced by new patients, there are left behind a few additional "treatment resistant" patients. Over a period of time these accumulate and tend to limit the mobility of patients entering and leaving this section. This hard core of continued treatment patients must be worked with actively. Each year a certain percentage of this group must be rehabilitated and released; otherwise the program will eventually bog down.

DISCUSSION

In a recent report Kramer (1) points out that the improved methods of psychiatric treatment in recent years have resulted in an earlier return of patients to the community during the first 24 months of hospitalization. "Beyond the first 24 months of hospitalization, there has been little improvement in the chances of return to the community." (p. 66). From Table 5 of Kramer's report, it appears that about 6% of patients who had been hospitalized for

a period of four years leave the hospital. This decreases to 0% after five years of hospitalization, demonstrating that little has been achieved in rehabilitating this group of patients. It appears that one of the biggest problems remaining in treating psychiatric patients is that of rehabilitating those patients who have failed to respond to treatment in the acute phase of their illness.

Evidence of overall success with the continued treatment patient at this hospital is illustrated by the fact that from this 128 bed section 107 patients left the continued treatment section during 1956. In view of Kramer's findings one may wonder why this overall turnover rate (84%) and the 49% discharge rate of treatment resistant patients (Table 1) are so unusual.

As superficially described, this program does not differ markedly from the continued treatment programs of other well staffed VA and state hospitals. The unusual results of this program, in the opinion of the authors, are attributed to the basic philosophy and approach to these patients, in part dealing with the two basic problems discussed previously.

PHILOSOPHY

We seek some uniformity of feeling toward our patients from all individuals who regularly come in contact with them. It has proved very helpful to individualize the patients and to place special emphasis on their strengths and assets rather than to think of them in terms of their psychopathology. This minimizes the attitude so common in many hospitals of regarding the chronic schizophrenic as a hopeless "case."

We do not regard psychosis alone as sufficient reason for hospitalization, but look at the "total patient" as he functions in daily living. With every member of our staff regarding himself as assisting rehabilitation and not acting in a custodial capacity, morale has been easy to maintain. Each patient is regarded as an individual and every attempt is made to see the problem from the patient's point of view, to deal with each patient through his perception of himself. We do not hesitate to change or revitalize our program for any patient. All members of the staff encourage and support each patient to develop his ideas in planning to leave the hospital. These ideas are examined carefully with the patient, certain of them are emphasized, and a definite plan is carried out.

Formal psychotherapy, EST and other traditional approaches are used infrequently with these patients. It is not to be implied that the psychopathology is ignored by the staff. What actually seems to occur is that *if* the patient is handled by attempting to help him become a social human being, the pathology takes care of itself. Frequently, as patients become friendly, responsible people, their delusions, apathy, etc. are greatly reduced. Even if this does not occur, a very delusional patient is sometimes discharged if he demonstrates his ability to get along adequately in a social setting.

As each patient moves through the building he takes on additional responsibility for managing his own life, along with increasing opportunity to develop social skills. On the open ward he is encouraged to participate in patient government, interact with the staff in ward meetings, and fulfill an individual work assignment. In this setting he readies himself for the transition from the hospital into the community.

EFFECT OF TRANQUILIZING DRUGS

During late 1955, tranquilizing drugs were introduced on a large scale to the continued

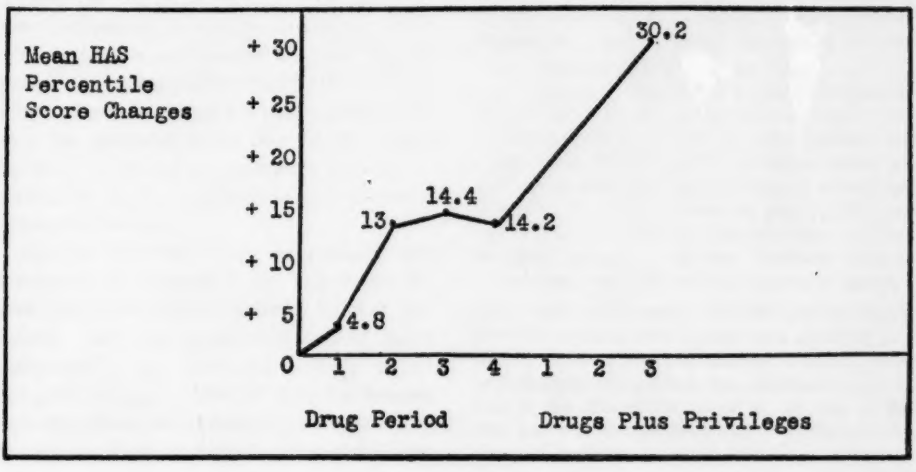
treatment patients of this hospital. This in part probably accounts for the increase from 25% (1955) to 49% (1956) discharge rate of the "hard core" continued treatment patients. It is impossible to say how many of these patients would have left the hospital without having been treated with these drugs, for it is apparent to us that the drugs are an important additional therapeutic tool.

Some clarification of the effect of these drugs and their role in an active continued treatment group of patients is possible, however. In a recent study (2), three groups of patients (10 in each group) were treated with reserpine, thorazine or a combination of these drugs for four months. At the end of the study there were 22 patients who had not improved sufficiently to be transferred to an open ward or to leave the hospital. However, 20 of these 22 patients were given privilege cards and encouraged to go on their scheduled activities unaccompanied by hospital personnel. Figure 1 presents the data of the Hospital Adjustment Scale (3) score changes for this group during the four months of medication and again three months after being on privileges. It would appear that the drugs *per se* had a positive effect on these patients, but that the increased responsibility and freedom, after four months on these drugs, had a striking effect also. It is apparent that the drug improvement had definitely leveled off by the fourth month and that the additional improvement resulted from a change in activities. Thus it may be concluded that the maximum drug effect can be reached only in combination with a realistic, aggressive activity treatment program.

In our program it is never our goal to administer these or other ataractic medications for the sole purpose of making patients easier to manage. Before these drugs were ever introduced our attitudes and policies toward the chronic patients had already

FIGURE 1

Mean hospital adjustment score changes during four months of medication followed by three months of medication plus a change in activities



eliminated virtually all management problems. It was rarely necessary to use any form of restraint or seclusion. If such problems as assaultiveness or incontinence appear in any patient, we still seek its correction through varying our approach rather than through simply increasing medications. These drugs are used, rather, to help the patient to achieve a higher level of social integration. He thus is able to participate to a greater extent in the outlined program.

CONCLUSION

The continued treatment section of this hospital has been highly successful in the rehabilitation of a large percentage of the "hard core" treatment resistant patients. Although our program does not differ materially from others in its structure, it is postulated that if our program is unique it is the result of our particular philosophy.

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F. LeGRANDE MAGLEBY, M.S.W., PH.D.

Should criminal and non-criminal patients in state hospitals be segregated?

A study recently completed by the writer [1] indicates diverse practices in state hospitals in the custody and treatment of the criminally insane.[2] For example, the Colorado and New Mexico state hospitals provide similar types of custody and treatment for criminally insane and non-criminal patients. In some instances these patients work side by side on the hospital farms and in the occupational therapy shops. In contrast, at the state hospital at Rusk, Texas, the majority of the criminally insane are housed in separate buildings which are completely surrounded by two "escape-proof" fences topped by electrically charged wires. Each fence has a separate gate which may be operated from one of the guard towers. A special alarm system may be activated by ward attendants in case of riot or attempted escape.

Should different types of custody and treatment be provided for criminally insane and non-criminal patients in state hospitals? Are the criminally insane more dangerous? Are they more likely to attempt to escape? Should they be housed separate from non-criminal patients? The answers to these questions, given as follows, are based upon reports submitted to the writer by the superintendents of state hospitals.

CURRENT PRACTICES

Seventy-six percent of 12,505 criminally insane patients reported in state hospitals on

DR. Magleby is assistant professor of social work at the University of Utah.

[1] Frank LeGrande Magleby, "Institutional Treatment of the Criminally Insane in the United States." Unpublished doctor's thesis, department of sociology, University of Utah, May 1956.

Questionnaires were mailed to the superintendent of each state hospital in the United States. The following were requested: (a) The number and some of the characteristics of criminally insane patients in each hospital and the types of custody and treatment provided for them on July 1, 1955; and (b) the opinions of the superintendents of state hospitals concerning the most desirable types of custody and treatment for the criminally insane.

[2] The criminally insane included persons legally classified as insane who (a) had been convicted of a felony, (b) were awaiting trial for a felony, (c) or were charged with a felony but considered to be insane at the time of the act or at the time of the trial and were exempt from trial or punishment by reason of insanity.

July 1, 1955 were housed apart from non-criminal patients, with 75% in separate buildings and 1% in buildings for non-criminal patients but in separate rooms. Twenty-four percent of the criminally insane reported were housed in the same wards with non-criminal patients.

In general, state hospitals with 400 or more criminally insane patients housed the majority of them in separate buildings and hospitals with fewer than this housed the majority of their criminally insane in the wards with non-criminal patients. Separate buildings were seldom used for the criminally insane in hospitals reporting fewer than 75 patients in this classification.

Ten state hospitals reported housing all of their criminally insane in separate buildings. These hospitals provided custody for an average of 773 criminally insane patients. Fifty-two state hospitals reported housing less than 10% of their criminally insane in separate buildings. These hospitals housed an average of only 58 criminally insane patients.

OPINIONS OF SUPERINTENDENTS

Sixty-three superintendents of state hospitals indicated, on questionnaires returned to the writer, the types of housing they believed would be most satisfactory for the criminally insane. Thirty-seven of these superintendents, (58.7%) believed that under ideal conditions all criminally insane patients in state hospitals should be housed in separate buildings. Twenty-three superintendents (36.5%) indicated that some criminally insane should be housed in separate buildings and others in buildings with non-criminal patients. Only three superintendents (4.8%) believed that all of the criminally insane should be housed in the wards with non-criminal patients.

Five superintendents pointed out that medical, social and psychiatric investigations should be the primary basis for the determination of the types of custody and treatment which should be provided for all mentally ill patients in state hospitals. They indicated that such investigations will disclose that many patients in both classifications (criminal and non-criminal) will have similar personality characteristics and treatment needs. Some of their statements are as follows:

There is no difference in the so-called "criminally insane" patients and other patients who have been admitted to our state hospitals for major psychoses. They are all classified under the same nomenclature. Criminally insane is used to designate patients with mental illness who have committed a felony. This could occur in any other department of our mental hospitals. Hardly a day goes by in a big mental hospital that someone does not become combative and occasionally one may lose his life.

I feel that there should be no special classification as "criminally insane," but that they should be classified according to their behavior. There is not a single state hospital which does not have many paranoid schizophrenias, who are oftentimes more dangerous than the ones in the criminal department.

I don't know on what criteria one could say that any given percentage of "criminally insane" should be housed apart. Our approach to this problem is to individualize in each case. For example, we have a 10-year-old boy who killed another person. His behavior in the hospital is quite acceptable and he attends classes, social activities, recreation, etc. On the other hand, we have some non-criminal patients who are non-criminal merely by virtue of the fact that they have to be locked up sometimes.

The mere fact of having committed an act which under some circumstances is considered criminal in nature does not, it seems to me, constitute sufficient criterion for deciding on housing, etc. Patients should be treated on the basis of their illness and the symptoms thereof and not on any artificial criterion such as I have mentioned.

Probably some of the most dangerous people we have in the institution have never been found guilty of any crime—whereas many of these sent to us from penal institutions have been involved in only minor and petty difficulties.

Acutely ill or recoverable cases can all be housed in the same quarters, whether criminally insane or non-criminal.

I will merely state that there is no distinction here in the treatment of the "criminal" and "non-criminal" population. The same precautionary measure would be utilized for a dangerous "non-criminal" as for a "criminal."

ARE CRIMINALLY INSANE MORE DANGEROUS?

Forty-six state hospital superintendents indicated they believed that fewer than half of the criminally insane are more violent or dangerous than the average non-criminal patients in state hospitals. Only five of the superintendents believed that all of the criminally insane are more violent or dangerous than average non-criminal patients.

The following statements, written on the questionnaires by four of the superintendents, indicate their belief that patients legally classified as criminally insane may not be more dangerous than many non-criminal patients in state hospitals:

Only the criminally insane with character disorders and psychopathically conditioned tend to be more dangerous and greater elopement problems.

Patients should be treated symptomatically, and the security should depend on the strength of their anti-social tendencies. A non-criminal patient may be potentially more dangerous to society than a criminal patient.

In our own experience the most serious injuries and other problems of conduct in the hospital have been presented by patients who have never been charged with any criminal offense. . . . To our way of thinking, the only significance to the provision of security measures in the case of mentally ill patients charged with crimes is satisfaction of the law and in this important area there would appear to be a serious conflict between psychiatry and the law.

Many of the mentally ill patients against whom no charge of crime has been brought are as seriously disturbed, if not more disturbed, and potentially more "dangerous," than the majority of patients charged with crimes and against whom maximum security measures are leveled. To me it is incomprehensible that patients who are mentally sick should be lumped together not on a basis of their sickness but on the basis of certain behavior which resulted from their illness, but it is an example of how good psychiatric judgment may be influenced by fear of public opinion and by outmoded legalistic concepts.

CRIMINALLY INSANE CHARGED WITH MURDER

Only 19% of 6,578 criminally insane patients in 51 state hospitals were classified as guilty of or awaiting trial for murder. Other patients were charged with forgery, theft, drunkenness, perjury, attempted suicide and other offenses. Judging from the

types and variety of the crimes committed by the criminally insane, it appears that many of them are not more dangerous than some of the non-criminal patients in state hospitals.

It was the opinion of 39 superintendents (67% of those reporting) that fewer than half of the criminally insane in state hospitals are more apt to attempt to escape than average non-criminal patients. Only five of the superintendents indicated they believed that all criminally insane patients should be classified in this manner.

TREATMENT NEEDS

The superintendents of state hospitals were asked to indicate the differences in medical and psychiatric treatment which were provided in their hospitals for criminally insane and non-criminal patients. No major differences were reported. The superintendent of one state hospital made the following comment: "The criminally insane sex deviates are given special classes."

Eighty-seven percent of the superintendents indicated they beleived the same medical and psychiatric treatment should be provided for both criminal and non-criminal patients. The following statements were made by three of these superintendents:

Outside of the additional protection for the community, there should be no difference in the medical-psychiatric treatment for the criminally insane than for the non-criminally insane population. We attempt to attain that end at this institution.

Medical and administrative problems in a hospital should not be determined on the basis of a patient's legal status.

I believe that the so-called criminal insane should be treated and handled in accordance with their psychiatric needs. I know no reason why a criminal act should be regarded other than in the light of psychotic behavior. Violent behavior and potential homicidal conduct can exist in non-criminal patients, but I contend the care and treatment of the two groups should be essentially the same.

DISCIPLINE

Only seven state hospitals indicated they provided different types of discipline for their criminally insane and non-criminal patients. Refer to the following comments:

No ground privileges for the criminally insane and they usually wear a uniform. Some exceptions are made.

The criminally insane are provided close supervision and limited privileges.

The criminally insane are housed in a building with greater security and with more personnel.

At the present time, the emphasis is upon guards for the criminally insane. Ground privileges, etc., are given only with the consent of the judge. The emphasis is upon obedience among the criminals.

Fifty-three superintendents, nearly 75% of the group reporting, believed that methods of discipline should be essentially the same for both criminal and non-criminal patients in state hospitals.

RECOMMENDATIONS

Should criminal and non-criminal patients in state hospitals be segregated? On the basis of completed questionnaires and written reports submitted to the writer by su-

perintendents of state hospitals, the following recommendations are made:

1. Hospitals which house all of their criminally insane in separate buildings and yet provide adequate custody and treatment should continue these practices. The majority of the 66 superintendents of state hospitals indicated that under ideal conditions criminally insane patients should be housed in separate buildings.

2. State hospitals which are unable to provide adequate facilities in separate buildings for their criminally insane (usually hospitals with fewer than 400 criminally insane) should house the majority of these patients in the same wards with non-criminal patients.

3. State hospitals should provide the same hospital atmosphere and similar types of custody and treatment for both their criminal and non-criminal patients.

4. The types of custody and treatment needed for all patients in state hospitals should be determined on the basis of individual needs by medical, psychiatric and social investigation. Legal classifications, criminal or non-criminal, should not be the primary basis for the determination of custody and treatment.

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". . . it is for many reasons unfortunate that this kindly removal of the afflicted person to a hospital in which he may be humanely cared for, protected from injury to himself or others and receive the best of medical treatment, removes him from further observation by the community. The lessons which would be learned by each community if its insane were cared for in its own sight, so to speak, would be exceedingly valuable. If people generally saw more of the insane after the first onset of the disease, they would learn many things which now are known only to a few. They would learn, for instance, that most of the insane are practically harmless; that mental troubles differ greatly in degree and in kind; and that patience, kindness and sympathy are the chief factors in healing the diseases of the mind as in healing many other ills. The seriousness of the affliction and the burden which it imposes on the community would be more fully realized, and there would be readier appreciation of the importance of any new light thrown by science upon the nature, origin, and preventability of insanity."—From an address by the late *Homer Folks,* published in "The Review of Reviews" in 1911. Mr. Folks was secretary of the New York State Charities Aid Association from 1893 to 1947.

ALFRED KADUSHIN, PH.D.

Social sex roles and the initial interview

The case work interview, like all interviews, is a psychosocial situation. It is difficult to precipitate out of the complex solution the discrete social and psychological components. One might hypothecate, however, that there are variations at different stages in the worker-client contact in the strength of the contribution made by each of the components.

During the initial contact the social component would seem to be the more influential determinant of the client's behavior in the interview. As the series of interviews continues, as the worker develops some emotional meaning for the client, the psychological component becomes progressively the more important determinant of the client's responses. The same process, although muted, would appear to be true for the worker's response to the client. The degree of variation in the worker's response is not so great as the client's because the worker, from the moment of initial contact, is consciously making an attempt to select responses that are in accordance with psychological realities rather than with social appearances. From the beginning the worker is responding to the demands of her professional role.

The client coming for his first case work interview has few guide-lines available that would help him to know what is expected of him. He has had frequent opportunities in his own experience, and vicariously through mass communication media, to learn something about the patterns of behavior that are appropriate for the patient in contact with a doctor, a client consulting a lawyer, a student in his relationship with a teacher. Very likely he has not had similar opportunities which prepare him for acting the role of the case work client. He therefore has little idea of the pattern of behavior which is appropriate and acceptable in such a role.

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The client has, however, a fund of knowledge and experience, even if he is not explicitly aware of this, of the appropriate and expected behavior in a wide variety of social situations which are, to all appearances, similar to the interview situation. Since the client is forced, from the moment of his entrance into the interview, to initiate and maintain a series of responses to the worker and since the client is frequently uncertain as to the acceptable pattern of such responses, it is to be expected that the client would select those which he has learned are appropriate in similarly structured situations. The male client in his first interview with a female caseworker would be strongly disposed to respond in terms of the social code of the role with which he is familiar—a man in contact with a woman. He will be less inclined to act in accordance with the demands of the role with which he is unfamiliar—the client in contact with the caseworker. Similarly, the Negro client in contact with the white worker, the young adolescent client in contact with the older caseworker, the client whose socio-economic status is lower than that of the worker, whose appearance and speech are obviously characteristic of upper middle-class breeding and background—all will tend to define the situation in terms of learning derived from previous social experience with such age, caste and class categories and to respond accordingly. Having "positioned" the worker in some social role, the client then organizes his responses so that they are reciprocally appropriate. Investing the worker with a social role based on observable age, sex, color, etc., provides a frame of reference for orientation and permits the client to know what is expected of him. Conversely, it helps organize his expectancy set with regard to actions he can anticipate from the worker. These actions are the institutionalized patterns of behavior which are concomitant with the role and hence to be expected of the person playing the role. Thus, initially, the code of interpersonal communication dictated by the broader social matrix for particular social roles is perhaps the more important determinant of the client's choice of responses within the case work interview.

If the client continues his contact with the worker, the worker's sex, age, class, caste, position become progressively less important as factors determining the client's responses. The client then sees the worker as something other than an older, white, middle-class woman, and these social considerations, although still present, do not take precedence over the psychological meaning of the worker for the client in dictating the pattern of client responses.

The worker from the start does not respond in terms of usual role expectations but in terms of her responsibilities as a caseworker. The client then faces the task of continuously reorganizing his perception of the worker in terms of the reality of her responses so that she emerges as an individual of a particular kind rather than remains a social stereotype. The response, then, is more likely to be to the worker as an individual, distorted by transference elements, rather than to the worker as a member of an age, sex, caste or class category. However, it should be noted that initial impressions and initial expectancies have a great deal of persistence.[1]

Bernard notes this change for the analytic interview in a somewhat different manner. She says: "When the analysis is just be-

[1] See Herbert H. Hyman, *Interviewing in Social Research*, Chicago, University of Chicago Press, 1954, 84–91, for a discussion of the persistence of initial expectations.

ginning a 'social role' or limited component of each person's total identity is more apt to be perceived in the situation, than as the analytic process mobilizes more of the total self." [2]

Hartmann similarly notes: "There is little doubt that the way in which the initial contact between the Frenchman, the Englishman, the New Yorker, the Bostonian and the psychoanalyst is established covers wide ranges, *e.g.*, from curiosity to restraint, familiarity to suspicion; certain of these attitudes are more frequent in one group than in another. However, as soon as this superficial and initial contact develops into transference the differences appear to be much more limited. . . . According to our clinical experience no significant difference exists in the formation of transference—positive or negative—or in its intensity, structure or essential manifestations." [3]

Clinically, this transition is exemplified in the statement made by several Negro patients to Dr. St. Clair, a white psychiatrist, "You know, Doc, I thought you were just another white man *at first.* I couldn't talk to you then." [4]

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[2] Viola W. Bernard, "Psychoanalysis and Members of Minority Groups," *Journal of the American Psychoanalytic Association,* 1(1953), 260.

[3] H. Hartmann, E. Kris and R. Lowenstein, "Some Psychoanalytic Comments on Culture and Personality," *Psychoanalysis and Culture,* G. Wilbur and W. Muensterberger, eds., New York, International Universities Press, 1951, 19.

[4] H. St. Clair. "Psychiatric Interview Experience with Negroes," *American Journal of Psychiatry,* 108 (August 1951), 114. See also Newman R. Gillem and F. Redlich, *The Initial Interview of Psychiatric Practice,* New York, International Universities Press, 1954, 68–71. The authors state that "roles play an especially important part in the initial interview because the participants have not had the opportunity to know each other as individuals and can therefore react to one another only in terms of how their individual personalities define their social roles."

This discussion is based on the level of the client's behavior, which derives from his membership in a cultural subgroup—a class, age, sex, color, ethnic, religious, etc., subgroup. He has learned through his particular group affiliations that certain patterned regularities of behavior are required, or at least expected, "in a given set of social relations." On the level of idiosyncratic experience—the unique socialization experience of any one individual—the group prescriptions may be altered. For example, generally the culture teaches the male to see the female as a nurturing, dependent, passive person. Certain patterned regularities of behavior in male-female relationships, deriving from this, are taught and learned. However, a particular male whose mother was aggressive and punitive has had a particular learning experience which contradicts the group teaching and this, rather than the group-prescribed behavior for the role, determines his actions in contact with females.

For most clients, however, group teaching and the unique socialization experience are congruent and reinforcing rather than contradictory and opposing so that behavior prescribed by the group as expected for a particular social situation is the behavior which the individual learns to present.

One should note too that the role expectations exert their greatest influence on the sectors of the interview which are role-linked, that is, where socially defined patterns of reciprocal behavior have some relevance. For instance, in the first contact between a male client and a female worker some of the interview content may be of a nature which is not affected in any way by society's prescription as to what is appropriate and proper for a man to say and to do when in contact with a woman. Socially defined role behavior, however,

applies generally to the more important and significant areas of interaction.

REVIEW OF PERTINENT LITERATURE

There is available some experimental and clinical validation for the contention that the code of communication dictated as appropriate for social role relationships exerts an influence on interaction during the interview. For convenience we will limit the discussion to sex roles since sex difference is immediately apparent and difficult to minimize. However, sex difference is merely one of a number of social variables —including class, age, ethnic, color, religious, etc., differences—which in part determine the client's responses in initial interviews.

The experimental material regarding the influence of sex-linked role demands on the interview are somewhat equivocal. Hyman [5] details an experiment which indicates that although the sex of the public opinion interviewer seems to be significant in conditioning the response of the interviewee if the interviewer is a male, this did not appear to be the case if the interviewer is a female. Since most of the female interviewers were more experienced than their male counterparts, it was suggested that their greater skill tended to mask or counteract the effects of sex-role differences.

Benny, analyzing somewhat similar material, summarizes by stating: "The least inhibited communication (between interviewer and interviewee) seems to take place between young people of the same sex; the most inhibited between people of the same age but different sex." [6] The factor of sex difference in influencing interaction seems to be clear here.

Curtis,[7] discussing the Rorschach, notes: "There is a significant difference between male and female examiners on the number of records with sex responses" where the patient population was exclusively male. However, Alden [8] reports for a similar group of patients in the same test situation: "There is no general trend (author's italics) in the direction of either inhibition or facilitation of interpretations with sexual content in the presence of a female examiner." This latter conclusion is supported by Postman,[9] who held the sex of the subject constant and varied the sex of the experimenter in an experiment concerned with perception of taboo words. He reports that "relative thresholds for taboo words are not significantly different in the presence of an experimenter of the opposite sex than they are in the presence of an experimenter of the same sex."

Worby,[10] in an experimental study, notes that the adolescent expresses a preference for a therapist of his own sex but this may be unique to this age group and in line with the important developmental problem

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[5] Hyman, *op. cit.*, 153–58.

[6] M. Benny, D. Reisman and S. Star, "Age and Sex in the Interview," *American Journal of Sociology*, 62 (September 1956), 152.

[7] H. S. Curtis and E. B. Wolf, "The Influence of the Sex of the Examiner on the Production of Sex Responses on the Rorschach," *American Psychologist*, 6 (1951), 345.

[8] P. Alden and A. Benton, "Relationship of Sex of Examiner to Incidence of Rorschach Responses with Sexual Content," *Journal of Projective Techniques*, 15 (1951), 231–34.

[9] L. Postman, W. C. Bronson and G. L. Gropper, "Is There a Mechanism of Perceptual Defense?", *Journal of Abnormal and Social Psychology*, 48 (1953), 215–24.

[10] M. Worby, "The Adolescent's Expectation of How the Potentially Helpful Person Will Act," *Smith College Studies in Social Work*, 26 (October 1955), 19.

of sexual identification encountered by the adolescent. Clinically the contention finds some support. Meyer [11] cites clinical experience to demonstrate some advantage of the female psychiatrist in contact with the female patient. Cowen [12] notes that two of the thirty-two patients intensively studied in a follow-up of client-centered therapy indicated that "they felt particularly inhibited because of the sex of their counselor—enough to impede therapeutic progress."

Haimowitz,[13] in another study of client-centered therapy, notes that the clinical material indicates that there are certain problems that a woman will discuss more readily with a woman, the same being true for the male.

Ingham [14] details a case history to stress the significance of sex roles in therapist-patient interaction.

Fleming [15] notes that she found that the sex of the therapist was an important consideration in group play therapy. In a guided interview study of the practice of 43 prominent psychotherapists the majority emphatically denied that the patients' sex had any effect on the success of the therapy although it did have an effect in special instances.[16]

AN EXPERIMENT IN MULTIPLE MATCHING

One of the difficulties in studying this problem in a clinical setting is that the interviews are in the nature of irreversible experiences. There is no way of knowing, once a case work interview is in progress, what a client might have offered or withheld if the role relationship between client and worker were the result of a different combination of elements. However, in a recent experiment conducted by the writer the client was simultaneously offered a choice of a variety of combinations of role partners within the same initial interview. The writer sat in as an observer in a series of case work intake interviews. Three of the four case workers who interviewed the clients in the experiment were female. The client thus had available a female case worker and a male observer. The possibility of a variety of "matchings" within the same interview was thus increased. The situation available to the client offered the opportunity of checking variations in reactions to the differences in combination.

A male client of a department of public welfare was discussing, with a female worker, a medical condition which limited his employability. The worker was attempting to get a clearer picture of this and the client refused any information. He indicated, however, that he was very ready to discuss this with the male observer if the case worker would step outside. The medi-

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[11] Blanche M. Meyer, "The Unique Role of Women as Therapists in Psychiatry," *Journal of the Medical Women's Association*, 57 (6, 1950), 18–23.

[12] E. L. Cowen and A. W. Combs, "Follow-up Study of 32 Cases Treated by Non-Directive Therapy," *Journal of Abnormal and Social Psychology*, 45 (1950), 232–58.

[13] N. R. Haimowitz and L. Haimowitz, "Personality Changes in Client-Centered Therapy," in *Success in Psychotherapy*, W. Wolff and J. Precker, (eds.), New York, Grune and Stratton, 1952.

[14] H. V. Ingham and L. R. Love, *The Process of Psychotherapy*, New York, McGraw-Hill Book Co., 1954, 232.

[15] L. Fleming and W. Snyder, "Social Personal Changes Following Non-Directive Group Play Therapy," *American Journal of Orthopsychiatry*, 17 (1947), 101.

[16] W. Wolff, *Contemporary Psychotherapists Examine Themselves*, Springfield, Ill., Charles C Thomas, 1956, 242.

cal problem, it was revealed, was in the genito-urinary area and the client's conception of what was proper in sex-linked role relationships inhibited him from disclosing this to the worker.

A female client said to her female case worker that she had been uncomfortable in discussing her pregnancy in the presence of the male observer. She regarded this as "women's business" which should not be discussed in the presence of a man with whom she was not on familiar terms. Had she been offered a male worker she would not have discussed this problem.

A male client of a county department of public welfare was discussing, in a very general manner, the situation which had prompted difficulty between his wife and himself. The interviewer, a woman, was unsuccessful in obtaining an elaboration of this material. Shortly before the end of the interview, the worker found it necessary to leave the room. When the client and observer were alone the client said to the observer that the information he had given the worker regarding his wife was only a small part of the story. He said: "I find it difficult to talk to one woman about another woman. I can't tell on one woman to another." He then went on to detail, to the observer, his wife's infidelity.

A female client in a family service agency in discussing the observation experience privately with the female case worker said that she had been hesitant to criticize her husband in the presence of the male observer. She had said at one point that "men are little boys anyhow." At that she became consciously aware of the observer and censored herself from making further uncomplimentary remarks about men in general. She indicated that she would have been prompted to act in this controlled manner if her case worker had been male.

Two clients in responding to the proposal that the observer be permitted to sit in on the interview indicated, by inference, their strong preference for an interviewer of their own sex and hence their recognition of sex-linked appropriate role behavior as they defined it. In both cases the client presented a problem of sexual adjustment in marriage. One female client said, in refusing permission to the observer to sit in, "It's pretty hard to talk about some things. If it weren't a man maybe all right but I am having trouble even talking with Dr. Smith (her family doctor) about this."

Another client asked if the observer were a man and then went on to refuse permission for the observer to sit in, saying, "I'll be talking about a lot of personal things. If a woman was coming in to observe it would be all right but not a man."

The influence of social conventions on sex roles was further noted in the responses of male clients who were interviewed by female workers to the discussion of material which is regarded as being within the special purview of the male. On these occasions they turned to the observer and ignored the interviewer. This was in sharp contrast to their conduct throughout other parts of the interview, when the observer was ignored. One client discussed a problem of his car in this manner, another his army experience, another his drinking habits, still another an important poker game. Since these activities are defined as being of primarily masculine interest, the client seemed to suggest by his actions that he felt the female worker would either be uninterested in, or incapable of understanding, this material. One might speculate as to whether such material would have been offered if the male client had been alone with the female worker.

IMPORTANCE TO SOCIAL WORK

There are a number of considerations which suggest the importance, for social work, of an awareness that institutionalized role patterned behavior conditions the client's response in initial contacts.

The reciprocal responses dictated as appropriate for a particular role relationship can impede or facilitate the client's feeling of freedom in communication. If motivation for help is great the impediments to ease in communication which derive from appropriately dictated role behavior can be overcome. However, for a great many clients this burden, in addition to all the other considerations which dictate opposition to seeking help, may be more than limited motivation can carry. Houwink says: "Color is an additional problem to be resolved within the case work relationship before client and worker can be free to relate to the individual human problems that lie beyond." [17] For color one might substitute sex or race or class difference as the "additional problem."

The substantial number of clients who fail to continue beyond the initial contacts indicate that frequently motivation for case work help is tenuous and has to be assiduously supported. Unless these impediments to rapport and ease in communication are reduced to a minimum the client may never get beyond the point where they cease to matter.[18]

Some of the explanation for the clinical fact, so amply documented by Pollak,[19] of the failure on the part of social work to offer successful service to fathers may lie in this analysis.[20]

In seeking other kinds of professional services the client can avoid such potential difficulties. A sick woman who feels uncomfortable about being examined by a male doctor can elect to ask for service from a female doctor. However, social work is peculiar in that the client of a social agency is not permitted a choice of the professional person offering service. The worker is assigned by the agency rather than selected by the client. Hence the client may be faced with the necessity of adjusting to difficulties in communication posed by social variables if he wants to continue contact.

Does this imply that the agencies have the responsibility of supplying every client with the worker who would, on the basis of our knowledge of social relationships, fall into those categories most likely to facilitate client freedom in communication? This is, of course, administratively infeasible. In many instances it may be psychodynamically in error in terms of the particular needs of a client. But even if it were administratively possible and in all instances psychodynamically correct, we would pay a price for the gains achieved.

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[17] E. Houwink, "Color Is an Additional Problem," *Mental Hygiene,* 32 (1948), 604.

[18] See M. Blenkner, *et al., A Study of Intake,* New York, Institute of Welfare Research, Community Service Society, June 1950, and J. Frings, *et al., A Study of Short-Term Cases,* New York, Research Department, Jewish Family Service, April 1951.

[19] O. Pollak, *Integrating Sociological and Psychoanalytic Concepts,* New York, Russell Sage Foundation, 1956, 177–217.

[20] While Pollak seeks to explain this in terms of social role relationship as it affects the worker's reluctance to offer service to the male client, M. Mead in *Keep Your Powder Dry* suggests that the explanation lies in the male client's view of the feminine nature and values of social work. This hypothesis receives some empirical confirmation in J. Seeley, A. Sim and E. Loosley, *Crestwood Heights,* New York, Basic Books, 1956. That this feminization of social work extends to the male practitioner as well is suggested in an interesting analysis of the general approach of the counselor in R. Farson, "The Counselor Is a Woman," *Journal of Counseling Psychology,* 1 (1954) 221–23.

Matching would probably make the client initially more comfortable; it probably would increase the empathic index of the relationship; it permits an intimate knowledge by the worker of the client's culture, which increases the probability of more consistent understanding. But if worker and client are matched in terms of social variables, because of the worker's similarity to the client he is more likely to be caught in the web created by reactivation of similar problems, more prone to overidentify, less capable of achieving a professional objectivity about the client's situation.

The solution, it would appear, lies not so much in matching but in developing greater skill on the part of the workers so as to minimize any difficulties that stem from role-linked behavior and in attracting to social work people who have the capacity to empathize with a great variety of clients in a great variety of situations. It would lie in a more explicit understanding of the social role determinants of the client's responses. It would lie, as well, in helping the client to understand more explicitly the real difference between the professional relationship and the specious social aspects of the professional relationship.

SUMMARY

The importance of social role considerations as a determinant of worker-client interview interaction, particularly during initial contacts, has been discussed. Previous experimental and clinical studies of the effects of one of these elements—sex—have been reviewed and some additional clinical material cited. The significance of this consideration for social work is discussed.

On bureaucracy

"This organizational paradox," as it has been called, stems from the fact that organizations often prevent the translation of unrest into social action. This is true because in order to accomplish their goals, organizations must establish a set of procedures or means. In the course of following these procedures, the persons to whom authority and functions have been delegated often come to regard them as ends in themselves rather than as means toward the achievement of the organization's goals. The inevitable result of this process is that the actual activities of the organization ultimately become centered upon the proper functioning of organization procedures, rather than upon the achievement of the initial goals. This phenomenon has been observed in a number of social movements in the process of becoming institutionalized.—*David L. Sills,* Bureau of Applied Social Research, Columbia University.

DAVID P. AUSUBEL, M.D., PH.D.

Ego development among segregated Negro children

Two different approaches can be taken to problems of ego development in encapsulated Negro communities. First, I would like to consider the personality development of the segregated Negro child as a special variant of the more typical course of ego development in our culture. Here the approach is normative, from the standpoint of a personality theorist interested in subcultural differences. In what ways does the ego development of the segregated Negro child differ from that of the textbook child growing up in the shadow of our dominant middle-class value system? Second, I would like to consider some kinds of and reasons for individual differences within this underprivileged group. Do all Negro children in the Harlem ghetto respond in the same way to the impact of their segregated lower-class environment? If not, why not? These second kinds of questions would be asked by a personality theorist concerned with idiosyncratic variability within a subcultural group or by a psychiatrist treating the behavior disorders of such children in a Harlem community clinic. Although limitations of time will not permit me to consider explicitly the implications of this material for such practical issues as educational practice and desegregation, I believe that many of the implications are self-evident.

Dr. Ausubel, who is professor of education in the University of Illinois College of Education, read this paper September 1, 1956 at the convention of the American Psychological Association in Chicago. He writes, "The assistance of Miss Lillian Cukier in its preparation is gratefully acknowledged."

OVERVIEW OF EGO DEVELOPMENT IN WHITE MIDDLE-CLASS CHILDREN

Before turning to a description of ego development in segregated Negro communities it may be helpful to examine briefly the typical middle-class model with which it will be compared. In doing this I do not mean to imply that the developmental pattern in suburbia is typical of the American scene. Obviously only a minority of America's children live in the ecological equivalent of suburban culture. Nevertheless it is still a useful model for comparative pur-

poses because it reflects the value system that dominates such official socializing institutions in our society as the school, the church, the youth organizations, the mass media and the child-rearing manuals. Hence it is the most widely diffused and influential model of socialization in our culture. It is the official model that most parents profess to believe in regardless of whether or not they practice it. It is the model that would most impress foreign anthropologists as typical of American culture.

The infant in suburbia, as in many other cultures, may be pardoned for entertaining mild feelings of omnipotence (2). Out of deference to his manifest helplessness, his altruistic parents are indulgent, satisfy most of his needs and make few demands on him. In view of his cognitive immaturity, it is hardly surprising then that he interprets his enviable situation more as proof of his volitional power than as reflective of parental altruism. As he becomes less helpless and more responsive to parental direction, however, this idyllic picture begins to change. His parents become more demanding, impose their will on him and take steps to socialize him in the ways of the culture; and by this time the toddler has sufficient cognitive maturity to perceive his relative impotence and volitional dependence on them. All of these factors favor the occurrence of satellization. The child surrenders his volitional independence and by the fiat of parental acceptance and intrinsic valuation acquires a derived status. As a result, despite his marginal status in the culture and his manifest inability to fend for himself, he acquires feelings of self-esteem that are independent of his performance ability. He also internalizes parental values and expectations regarding mature and acceptable behavior.

In suburbia, derived status constitutes the cornerstone of the child's self-esteem until adolescence. Beginning with middle childhood, however, forces are set in motion which bring about preliminary desatellization from parents. Both in school and in the peer group he is urged to compete for a primary status based on his academic proficiency, athletic prowess and social skills. School and peer group legislate their own values, impose their own standards and also offer him a subsidiary source of derived status insofar as they accept him for himself in return for his loyalty and self-subordination. All of these factors tend to devalue the parents and to undermine their omniscience in the child's eyes. The home becomes only one of several socializing agents that foster the development of aspirations for academic and vocational success and the pattern of deferred gratification necessary to achieve them.

Nevertheless, until adolescence parents remain the major socializing agents and source of values in the child's life. Compared to the derived status obtained from parents, the primary status available in school and peer group plays only a subsidiary role in the total economy of ego organization.

EGO DEVELOPMENT IN SEGREGATED NEGRO COMMUNITIES

In the early childhood. Many of the ecological features of the Harlem Negro environment that impinge on personality development in early childhood are not specific to Negroes as such but are characteristic of most lower-class populations. Lower-class parents, for example, are generally more casual, inconsistent and authoritarian than middle-class parents in controlling their children, and resort more to harsh, corporal forms of punishment (9, 10, 21, 22). Even more important, they extend less succorant care and relax closely monitored supervision much earlier than their middle-

class counterparts (8, 9, 11, 17). Lower-class children are thus free to roam the neighborhood and join unsupervised play groups at an age when suburban children are still confined to nursery school or to their own backyards. Hence, during the preschool and early elementary school years the lower-class family yields to the peer group much of its role as socializing agent and source of value and derived status. During this early period lower-class children undergo much of the desatellization from parents that ordinarily occurs during middle childhood and preadolescence in most middle-class families. They acquire earlier volitional and executive independence outside the home and in many cases assume adult responsibilities such as earning money and caring for younger siblings. Abbreviated parental succorance, which frustrates the dependency needs of middle-class children and commonly fosters overdependence (27), has a different significance for and effect on these lower-class children. Since it reflects the prevailing subcultural norm and since the opportunity for early anchorage to a free-ranging peer group is available, it tends to encourage the development of precocious independence.

All of the foregoing properties of the lower-class environment also apply to the Harlem Negro community. In addition, however, homes are more apt to be broken, fathers are more frequently absent and a matriarchal and negative family atmosphere more commonly prevails (7, 12). The lower-class Negro child is frequently raised by his grandmother or older sister while his mother works to support the family deserted by the father (12).

Being a Negro, however, has many implications for the ego development of young children that are not inherent in lower-class membership. The Negro child inherits an inferior caste status and almost inevitably acquires the negative self-esteem that is the realistic ego reflection of such status. Through unpleasant contacts with white persons and with institutionalized symbols of caste inferiority (*e.g.*, segregated schools, neighborhoods, amusement places) —and more indirectly through mass-media and the reactions of his own family—he gradually becomes aware of the social significance of racial membership (13). He soon learns "that skin color is important, that white is to be desired, dark to be regretted" (20). He perceives himself as an object of derision and disparagement (13), as socially rejected by the prestigeful elements of society and as unworthy of succorance and affection (12). Having no compelling reasons for not accepting this officially sanctioned negative evaluation of himself, he develops deeply ingrained feelings of inferiority (30).

In addition to suffering ego deflation through awareness of his inferior status in society, the Negro child finds it more difficult to satellize and is denied much of the self-esteem advantages of satellization. The derived status that is the principal source of children's self-esteem in all cultures is largely discounted in his case since he can satellize only in relation to superordinate individuals or groups who themselves possess an inferior and degraded status. Satellization under such conditions not only confers a very limited amount of derived status but also has deflationary implications for self-esteem. We can understand, therefore, why young Negro children resist identifying with their own stigmatized racial group (5), why they seek to shed their identities (12) and why they prefer the skin color of the culturally dominant caste (5, 15, 20). And by rejecting their own racial group they inevitably increase the burden of self-rejection, since sooner or later they must acknowledge their racial membership.

In middle childhood and preadolescence. During middle childhood and preadolescence the ego development of the segregated Negro child also reflects the influence of both general social class factors and more specific racial factors. As already pointed out, early experience in fending for himself both in the wider culture and in the unsupervised peer group, as well as in exercising adult-like responsibilities, accomplishes precociously much of the desatellization from and devaluation of parents characterizing the ego development of middle-class children during this period.

In these developments school plays a much less significant role among lower-class than among middle-class children. The lower-class child of school age has fewer illusions about parental omniscience for the teacher to shatter and is coerced by the norms of his peer group against accepting her authority, seeking her approval or entering into a satellizing relationship with her (9). School can also offer him very little in the way of either current or ultimate primary status. His parents and associates place no great value on education and do not generally encourage high aspirations for academic and vocational success, financial independence or social recognition (9, 17, 24); and even if they did, as Allison Davis puts it, academic achievement is a valueless reward for a child who soon comes to realize that professional status is beyond his grasp (9). Hence, anxiety regarding the attainment of internalized needs for vocational prestige does not drive the lower-class child to excel in school (9). Also, because of low achievement and discriminatory treatment, he fails to obtain the current rewards of academic success available to middle-class school children (9). On what grounds could a child immersed in an intellectually impoverished environment be expected to actualize his genetic potentialities for verbal and abstract thinking when he is unmotivated by parental pressures, by ambitions for vocational success or by the anxiety associated with realizing these ambitions?

The lower-class child's *expressed* levels of academic and vocational aspiration often appear unrealistically high (12), but unlike the analogous situation in middle-class children these do not necessarily represent his *real* or functional levels of striving. They more probably reflect impairment of realistic judgment under the cumulative impact of chronic failure (26) and low social status (16), as well as a compensatory attempt to bolster self-esteem through the appearance rather than the substance of aiming high. Lacking the strong ego-involvement which the middle-class child brings to school work and which preserves the attractiveness of academic tasks despite failure experience (25), he quickly loses interest in school if he is unsuccessful. Finally, since he does not perceive the eventual rewards of striving and self-denial as attainable for persons of his status, he fails to develop to the same degree as the middle-class child the supportive traits of ego maturity necessary for the achievement of academic and vocational success (9). These supportive traits include habits of initiative and responsibility and the "deferred gratification pattern" of hard work, renunciation of immediate pleasures, long-range planning, high frustration tolerance, thrift, orderliness, punctuality and willingness to undergo prolonged vocational preparation (9, 17, 24).

All of these factors inhibiting the development of high-level ego aspirations and their supportive personality traits in lower-class children are intensified in the segregated Negro child. His over-all prospects for vertical social mobility, although more restricted, are not completely hopeless. But

the stigma of his caste membership is inescapable and insurmountable. It is inherent in his skin color, permanently ingrained in his body image and enforced by the extra-legal power of a society whose moral, legal and religious codes proclaim his equality (30). If this situation exists despite the authority of God and the U. S. constitution, what basis for hope does he have? It is not surprising, therefore, that in comparison with lower-class white children he aspires to jobs with more of the formal trappings than with the actual attributes of social prestige; that he feels impotent to strike back at his tormentors; that he feels more lonely and scared when he is by himself; and that he gives more self-deprecatory reactions when figuratively looking at himself in the mirror (12). He may have less anxiety about realizing high-flown ambitions than the middle-class child, but generalized feelings of inadequacy and unworthiness make him very prone to overrespond with anxiety to any threatening situation. In view of the general hopelessness of his position, lethargy, submission and passive sabotage are more typical than aggression of his predominant reaction to frustration.

Negro children and lower-class white children who attend schools with a heterogeneous social class and racial population are in a more favorable developmental situation. Under these conditions the unfavored group is stimulated to compete more aggressively with the more privileged group in everyday contacts and in aspirational behavior (4). In their self-judgments they compare themselves with actual models and do not feel particularly inferior (12). Negro children in segregated schools, on the other hand, are not only deprived of this stimulation but in comparing themselves to other children paradoxically feel more depressed and less able to compete adequately (12), despite the fact that their actual contacts are confined to children in the encapsulated community who are patently no better off than they are. Apparently, then, they must use idealized mass-media models as the basis for comparison.

Other factors also contribute to the more serious school retardation of segregated Negro children: The incentive of reaching the average level of proficiency in the group is not very stimulating since the mean and even the somewhat superior child in this group are still below grade level; broken homes, unemployment and a negative family atmosphere are more prevalent; teachers are of poorer quality, tend to be overly permissive and to emphasize play skills over academic achievement; and pupils perceive teachers as evaluating them more negatively and as more concerned with their behavior than with their school work (12).

SEX DIFFERENCES

One of the most striking features of ego development in the segregated Negro community is the relatively more favored position enjoyed by girls in comparison to the middle-class model. It is true that middle-class girls have certain advantages over boys in early ego development. Since girls perceive themselves as more highly accepted and intrinsically valued by parents (3) and have a more available emulatory model in the home (23), they tend to satellize more and longer. In addition to enjoying more derived status in the home, they can also acquire more primary status from household activities (23) and from school achievement. The opportunity for acquiring primary status in school is greater for girls than for boys because of their superior verbal fluency and greater conformity to adult authority and because school success is less ambivalently prized by their peers.

In general, girls are less negativistic (14), more amenable to social controls (19) and less alienated from adults.

Middle-class boys, however, are not too badly off. Their mothers tend to prefer them to girls (27) and their fathers are responsible and respected status figures in the home and the principal source of economic security. Furthermore, although girls enjoy more *current* primary status during childhood, boys have higher ultimate aspirations for primary status; their aspirational level both for laboratory tasks (29) and for possessions and achievement (6) are higher. Unlike boys, girls do not really expect to prove their adequacy and maintain their self-esteem as adults by means of their vocational accomplishments. Their fathers are satisfied if they are "pretty, sweet, affectionate and well-liked" (1). Finally, the superordinate position of men in our society, as well as the accompanying male chauvinism, is reflected in childhood sex roles. From an early age boys learn to be contemptuous of girls and their activities; and although girls retaliate in kind by finding reasons for deprecating the male sex they tend to accept in part the prevailing view of their inferiority (18). Whereas boys seldom if ever desire to change sex, girls not infrequently wish they were boys (31). The male counterpart of a "tomboy" who relishes sewing and reads girls' books is indeed a rarity.

In contrast to this picture, we find girls in the segregated Negro community showing much greater relative superiority in academic, personal and social adjustment (12). They not only outperform boys academically by a greater margin but also in all subjects, rather than only in language skills (12). They have a greater span of attention, are more popular with classmates, show more mature and realistic aspirations, assume more responsible roles and feel less depressed in comparing themselves with other children (12). Adequate reasons for these differences are not difficult to find. Negro children in this subculture live in a matriarchal family atmosphere where girls are openly preferred by mothers and grandmothers and where the male sex role is generally deprecated. The father frequently deserts the family and in any case tends to be an unrelaible source of economic and emotional security (7, 12). Hence the mother, assisted perhaps by her mother or by a daughter, shoulders most of the burdens and responsibilities of child rearing and is the only dependable adult with whom the child can identify. In this environment male chauvinism can obtain little foothold. The preferential treatment accorded girls is even extended to opportunities for acquiring ultimate primary status. If the family pins all of its hopes on and makes desperate sacrifices for one child, it will often be a daughter in preference to a son. Over and above his handicaps at home the Negro boy also faces more obstacles in the wider culture in realizing his vocational ambitions, whatever they are, than the Negro girl in fulfilling her adult role expectations of housewife, mother, nurse, teacher or clerical worker (12).

It seems, therefore, that Negro girls in racially encapsulated areas are less traumatized than boys by the impact of racial discrimination. This is precisely the opposite of what is found in studies of Negro children from less economically depressed and less segregated environments (13, 28). The discrepancy can be attributed perhaps to two factors. First, the preferential treatment accorded girls in the encapsulated community is more pervasive, unqualified and continuous. Second, unlike Negro girls in mixed neighborhoods, these girls are less exposed to slights and humiliation from white persons.

INDIVIDUAL DIFFERENCES IN REACTIONS TO THE SEGREGRATED NEGRO ENVIRONMENT

Only extreme cultural deterministsts would argue that all children in the encapsulated Negro community necessarily respond in substantially identical ways to the impact of their social environment. Although common factors in cultural conditioning obviously make for many uniformities in personality development, genetically determined differences in temperamental and cognitive traits as well as differential experience in the home and wider culture account for much idiosyncratic variation. Would it be unreasonable, for example, to anticipate that an intellectually gifted Negro child in this environment might have a fate different from that of an intellectually dull or average youngster; that an active, assertive, outgoing and tough-skinned child might react differently to discriminatory treatment from one who is phlegmatic, submissive, sensitive and introverted?

Differences in early socializing experience with parents are probably even more important, especially since they tend to generalize to interpersonal behavior outside the home. At this point it is worth noting that generally speaking racial discrimination affects children indirectly through their parents before it affects them directly through their own contacts with the wider culture. This indirect influence is mediated in two ways. First, general parental attitudes toward the child are undoubtedly determined in part by the parent's own experience as a victim of discrimination. Some racially victimized parents, seeking retribution through their children, may fail to value them intrinsically and may place exaggerated emphasis on ego aggrandizement. Others may be so preoccupied with their own frustrations as to reject their children. Still others may accept and intrinsically value their children, and through their own example and strength of character encourage the development of realistic aspirations and mature, self-disciplined behavior. Second, parents transmit to their children some of their own ways of responding to discrimination, such as counter-aggression, passive sabotage, obsequious submission or strident counter-chauvinism.

Much individual variability therefore prevails in the reactions of children to minority group membership. Fortunately, sufficient time is available for establishing some stable feelings of intrinsic adequacy within the home before the impact of segregation on ego development becomes catastrophically destructive. It was found, for example, that Negro children who are most self-accepting also tend to exhibit more positive attitudes toward other Negro and white children (28). Hence, while appreciating the generally unfavorable effects of a segregated environment on all Negro children, we may conclude on the more hopeful note that the consequences of membership in a stigmatized racial group can be cushioned in part by a foundation of intrinsic self-esteem established in the home.

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JOSEPH G. DAWSON, PH.D.

Psychotherapy with a chronic schizophrenic patient

Although there is a growing body of clinical evidence supporting the hypothesis that schizophrenia is not an irreversible process in many patients, there have been few delineations as to what specific therapeutic factors contribute to changes in this process. Part of the difficulty may lie in the belief held by many that schizophrenia is not one disease but several, all of which may be represented by similar symptom constellations. As a result of the lack of adequate theory and factual knowledge about the process itself, methods advocated and employed in the psychotherapy of schizophrenic patients show a wide divergence in practice. Current evidence also supports a belief that the process may be modified or altered by psychological or empirical pharmacological methods.

There are two purposes for presenting this report. One of these is to give an example of successful psychotherapy with a catatonic patient whose prognosis was considered extremely poor. The second, and perhaps more important, is to present this patient's post-psychotic record of achievement. This is significant since some theories about the remission of schizophrenia usually emphasize post-psychotic level of compensation and not new achievement.

CASE HISTORY

Henry was born in a midwestern city in 1923. His father was a small business man who had attained a fair degree of economic security. His mother was an industrious woman who not only took care of the home but as Henry and his younger brother grew older helped her husband in his business. Both parents set high standards for the children.

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Henry had a psychiatrically uneventful childhood except for being somewhat shy and bashful. He was graduated from high school at 16 as president of his class, and during his latter years in high school he worked on a part-time job of some responsibility. His associates described him as popular with both sexes.

In 1942, following graduation, Henry volunteered for training as an Air Force cadet. As he progressed through flight training his reports were creditable, he received his wings and commission and was assigned to the 8th Air Force in England as a pilot. Following his eighteenth mission over Germany his B-17 was forced down in the North Sea where he was rescued by a DO-X flying boat and taken to a Nuremberg prison camp.

At first Henry made a good adjustment to camp life but gradually he began to withdraw and became very abusive toward his fellow prisoners and captors. At this time the prisoners were compelled to undergo several forced marches on starvation rations. As the patient's malnutrition increased he was unable to meet the heavy physical demands of the forced marches and was treated very harshly by his captors. (Henry's weight when captured was about 200 pounds and when he was liberated by the allied armies his weight had decreased to approximately 94 pounds.)

Following his release he was returned to an army hospital, which later became a veterans' hospital.

Henry's clinical progress was static even though his treatment included several "series" of electroshock therapy and extensive insulin deep coma therapy. During this 2-year period his psychiatrist also attempted amytal exploratory interviews and other psychotherapeutic contacts with no observable changes in his patient's behavior.

ON ADMISSION

A picture of his mental status follows. 11–16–46: The patient is a neat, clean, tidy, uncooperative individual, who walks around the ward in a diffident, indecisive, hesitant manner. He is seclusive and tense and at times refuses to eat with the other patients. He shows stubbornness and negativism. When he walked to the examiner's room, it was necessary to coax him to enter; he then hesitated at the doorway and backed out of the room. The patient was coaxed to sit in a chair and in a minute or so he quickly stood up, paced the floor and had to be coaxed to sit in the chair again. This behavior was repeated throughout the interview. The patient speaks slowly and shows much blunting, is incoherent, irrelevant and very circumstantial, and is evasive and suspicious. He mutters to himself and repeats many phrases. His countenance is expressionless and there is flattening of the affect. The patient feels somewhat depressed and states that he feels that way because he is locked up. He also resents the fact that he is a former officer and is treated like any patient. He resents being pushed around by the attendants and other patients and feels that as an officer he should be treated with dignity and respect. He refuses to accept the fact that he is no longer an officer but a civilian. He denies ever having masturbated and refuses to discuss it. The rigidity of this patient about sex is quite marked and shows a moral inhibition implanted during childhood. Hallucinations and delusions are denied. He is well oriented in all three spheres; memory for remote and recent events is spotty and inaccurate. General knowledge is fair and calculation is good.

The patient shows a complete lack of insight because he states there is nothing

wrong with his mind and he came to the hospital just to put some flesh on his bones. Laboratory examinations are negative.

Diagnosis: Schizophrenia, catatonic type.

Prognosis: Poor; the patient is incompetent.

The progress notes of his physician are included since they supplement the picture of the patient's behavior as given on the mental status examination. It is also interesting to observe the development of counter-transference feelings in his therapist. As the months passed Henry's lack of response seems to have become quite threatening to his therapist.

PROGRESS NOTES

12–18–46: The patient completed the first series of 18 electroshock treatments. Before shock the patient's behavior was described as catatonic, rigid, hesitant. He now speaks irrelevantly and incoherently, is "blunted" and fails to respond emotionally. He is not hallucinating, but has an intense preoccupation with bodily conditions. He lacks insight and is apathetic. At the conclusion of the shock he was considered unimproved and placed on insulin therapy.

3–10–47: Patient stands with both feet close together, his body upright and rigid, his head slightly bowed. He keeps this position for long periods of time and says almost nothing to anyone. He was engaged in conversation today and seemed to have the idea he will be out of here soon. He says everything is in the record, that I can get the information there and need not ask him about it at all. He is just waiting for his papers to be signed so he can go home. The patient was told point-blank there were no papers made out for him, that he was not going home, and that information was not complete. He reacted to this by walking away.

3–18–47: The patient is religiously avoiding the examiner and staying clear of him at all times. I have had no part of this delusional content and I will do for him what I can. He reacts in a very negative way.

On 3–26–47: The patient continues his negative reaction. There is absolutely nothing about this man that has changed. He still hangs on to the delusion that he will be out of here soon; that it's only a matter of completing the signatures on the necessary papers. He is very catatonic and stands in one position for long periods of time, walking away when spoken to.

4–2–47: The patient refused to eat but when threatened by force took food. He believes some sort of grandiose delusion, because he cannot imagine that he would be asked to eat in a room with a colored attendant standing by. The attendant had to leave.

4–8–47: The patient is so resistive and uncooperative that nothing can be done for him. He has had shock treatment to no avail and should be transferred to a chronic hospital.[1] He spends much time in a catatonic position, standing still and erect in one place for long periods of time.

4–18–47: The patient continues to use every effort to avoid even the most casual contacts by me. He walks away in an angry way when, at times, I say "good morning" to him. Efforts to talk to him are completely in vain and there has been no success whatever in efforts to obtain a trans-

[1] The term "chronic" as used here is no longer employed to designate hospitals in the Veterans' Administration.

ference situation with him. For the past week I have taken the attitude that I don't want to talk to him, or see him for that matter, but his whole reaction to it is nil, he behaves in the same resistive, negative manner.

4–29–47: The patient is unchanged and is impossible to approach. His mother cornered me in the hall recently. She is a most difficult person to talk to, and takes the attitude that she knows what her son's trouble is. She gives the reasons she thinks to be responsible and expects the psychiatrist to agree with her. When he does not, she takes the attitude that the psychiatrist is accusing her of being responsible for her son's insanity. She has a great deal of guilt about his condition.

5–8–47: No change in the patient's condition.

5–14–47: No change in the patient's condition. He is as resistive and negativistic as ever.

6–2–47: No change.

6–14–47: About a week ago the patient was invited to my office and when he refused to come in I told him that his release from this hospital was a matter which I would have to decide and if he didn't talk to me he would be here indefinitely. He flew into a rage which passed off after some hours. He has changed a little lately in that he is not quite as anxious to show me that he would do everything in his power to keep from talking to me. I have made no more approaches to him and it must necessarily be a long time before I do.

6–21–47: The patient continues to stay clear of any attempt to talk to him. He is not as insistent about this, however, and future attempts will be made to contact him, but the going will be slow.

6–28–47: The patient is as hopelessly psychotic as ever; he cannot be contacted. He struck a nurse a light blow when she did not accept the statement that he was not a patient. He stands for such long periods of time that his ankles have become edematous and the only way we can get him off his feet is to put him in cold packs. I believe this patient should have prefrontal lobotomy because he is not responding to electroschock or to insulin. He has been psychotic for over two years and there has been little change in the nature of his symptoms. Symptomatology indicates a very strong conscience in an obsessive compulsive nature but he has no previous history of antisocial tendencies or immoral trends. He is a ward problem, and in the opinion of all members of the staff he is hopeless. I have tried every trick I know of to get into contact with him but he is amazingly rigid in resisting any effort, no matter how slight, to contact him.

7–4–47: The patient's condition seems, if anything, somewhat worse. His eating is becoming poorer and it has been necessary on occasion to feed him with a tube.

7–21–47: The patient was seen at weekly conference and presented for consideration for prefrontal lobotomy. It was decided he should be given sodium amytal and a further course of insulin shock therapy prior to any psycho-surgery. Intravenous amytal loosened the patient up so that he talked freely; he smoked cigarettes, and talked at great length. It appeared that the general idea underlying his somewhat confused method of expressing himself was that he had been held here because something was wrong in the record which had to be straightened out. His opening statement was that he was definitely superior to anyone. The central idea seems to be that the

patient is falsely accused of something that they are trying to get him to admit or do this same "black deed." He does not indicate what it is. I have no doubt that it is of homosexual nature. His remarks so often skirt this subject. When he is questioned further he shies away from the subject in a rigid fashion. So far all his productions under amytal are essentially an elaboration of his main theme: "I will just wait right here until you sign the papers for my release; all the papers are in order and all they need is a signature." He points out how he has worked so desperately hard all his life and particularly in the army in order to have a good record and attend college when the war was over. He explains how well he knew the "book" —quotes army regulations—how he conformed to every detail and got his men to conform to them. Then he trails off in a confused stream of talk which seems to center in an attempt on his part to justify what he did. It is all very vague. There are a few indications that he is developing an attachment for me but this is expressed in such involved fashion that the outcome is yet to be seen. He is seen now without amytal but there is no response when the drug is not used. He speaks not at all, but only acts out his ideas, which are not too difficult to follow. Amytal interviews will be continued.

7–26–47: Daily sodium amytal interviews are continued. The patient is not allowed to ramble or dwell on his delusions—that all he is waiting for is his release papers to be signed so he can go home. He has expressed the idea that this organization has victimized him only so that we would have some unfortunate to fill a bed on the ward and that I am under the command of the army so I am holding him here. He will not accept the fact that I am a doctor and am keeping him here only because he is ill. It has been repeatedly pointed out to him that if his parents wanted they could take him out of here tomorrow. It has also been pointed out to him that he has often fought with his mother for not taking him out of here. He is as yet unable to see the light and insists that he is not mentally ill and is just waiting for his release. He still refuses to eat most of the time, and refuses to take a walk with me because this apparently represents something shameful to him. I am willing to speculate that there is a concealed homosexual wish in the patient which he is identifying with leaving this institution. When he walks out of here it means that everyone will know he is wrong. He will not give up his catatonia because he is going to prove them wrong. Hence he is in an impossible dilemma. Naturally, other factors are present, possibly more important ones. However, I refuse to be taken in by his statement that he is standing there waiting for his release. I believe he is standing in a catatonic state waiting for his normal homosexual component to vanish.

8–2–47: The patient has become so difficult to reach that it's essentially impossible to continue sodium amytal interviews. During the coming week oral amytal will be tried and then insulin shock.

8–9–47: The patient has erratic eating habits. He eats meat and potatoes at noon but nothing else throughout the day. Now and then he will eat a good meal. His condition is essentially unchanged. He will be placed on insulin shock therapy in two days. He will have to be given glucose by stomach tube because his veins are in such poor condition.

8–11–47: His therapist had the patient seen by a visiting consultant who gave the fol-

lowing opinion: "This patient is a chronic schizophrenic characterized by many catatonic symptoms—resistiveness, negativism, refusal to eat, rigid posture, etc. His previous therapy has consisted of EST and a rather inadequate course of insulin. He was recently considered for lobotomy because of failure to respond to other treatment; however, it is felt that a more adequate course of insulin therapy is indicated before further consideration of lobotomy. In view of poor veins it is suggested that nasal glucose or sugar feedings be used during insulin therapy rather than intravenous methods, thus leaving his veins for use in an emergency."

8–16–47: The patient is now receiving insulin shock therapy. This morning he was perspiring quite freely but not in coma. He reacts in the same old way—quite catatonic.

8–23–47: Insulin therapy continues and the patient shows no change. The other day he had to be threatened with tube feeding to be made to eat.

8–30–47: The patient is continued on insulin shock therapy and is in coma frequently. He refuses to eat and frequently sinks into coma after the evening meal. At that time he will take a liquid feeding but only after considerable coaxing. He is quite a problem and a strain on the personnel. He seems slightly more spontaneous, however. Nevertheless, I doubt if any results will be obtained from this therapy.

9–6–47: The patient is getting shock and his catatonic behavior continues right on throughout except that occasionally he has a delayed reaction and will talk a great deal or reveal his vindictiveness and highhandedness. He makes impossible requests and carries on in a superior way. After he has a little orange juice he is his old catatonic self again.

9–20–47: Insulin therapy continued with no appreciable results so far. The patient continues in his catatonic state.

9–27–47: The patient had convulsions under insulin shock therapy the other day but recovery was uneventful. No change in his mental state.

10–4–47: His treatment has been completed but there is no change in the patient's behavior.

Another consultant's opinion at this time follows: "This patient's behavior has remained markedly consistent during the past eight months despite all therapeutic efforts to produce any change for the better. At no time during this period have I observed any reaction in him that would even indicate a trend to spontaneous recovery. It is my opinion that only one therapeutic means is left for us to try and that is prefrontal lobotomy.

"Diagnosis: Schizophrenia, catatonic type.

"Treatment: Prefrontal lobotomy."

Another consultant's opinion, given October 28, 1947, stated: "This patient's condition has remained the same regardless of the therapy attempted. It is my opinion that he should be transferred to another hospital for custodial care.

"Diagnosis: Schizophrenia, catatonic type."

Henry's catatonic behavior continued and his physician referred him to various services for pre-lobotomy tests and evaluation. During the latter part of December 1947 the author was assigned to do the psychological examination.

THERAPY

Initial contact with Henry was in a small private room on a closed ward. His face

and body were covered with a severe dermatitis. In spite of his reclining position he maintained a rigid posture, as if he were standing at attention.

The examiner spoke to Henry in a reassuring manner, attempting to convey the general impression that the examiner understood his feelings about being in the hospital, stressing his desire to talk to the patient, and suggesting that the patient get up out of bed and cross the hall to an office. The examiner then left the room. There had been no overt response until this time. In a few minutes the bed creaked and Henry appeared at the door of his room. He approached the threshold of the door, paused and retraced his footsteps, approached again and repeated this behavior until finally, with what appeared to involve a considerable decision, he passed through the doorway. Henry repeated this behavior before the door of the examiner's office.

Entering the room he stood at attention by the desk facing the examiner, his head bowed and his eyes closed. When the examiner explained the purpose of the interview the patient made no response.

Believing that the patient was probably "untestable," but feeling there might be some possibility of establishing communication, the examiner again stated that he would like to know about the patient's situation in order that he might better understand why the patient was in the hospital. Henry then, with much blocking, related the story that he had given his previous therapist—that he expected to be out of the hospital in a short time and that he was being considered by a board and if everything was in order he would be discharged. The examiner did not contradict this delusion but accepted it as the patient's interpretation of his reality.[2] After some additional expressions of understanding by the examiner, Henry was told that it was necessary for the examiner to leave for a short period and that he could return to his room.

When the examiner returned he described the reason for his absence. The examiner had attended a Catholic wedding ceremony of a nurse formerly on the insulin ward. Henry seemed quite interested in hearing about the ceremony and at the close of the description the examiner noticed tears in the patient's eyes.

Responses at this time consisted mostly of nods or of signs indicating his agreement or disagreement with the examiner's statements. The examiner then closed the interview by saying he would see Henry the following Monday.

Before the next interview a conference was held with several staff members, including the senior psychiatric consultant, and it was decided to abandon efforts to examine Henry but to make every attempt to further therapeutic contact and to promote the beginnings of a relationship.

During the first week Henry was seen daily for three to four hours a day. At the end of this time he was speaking to the therapist in response to questions and he was asked if he would like to leave the closed ward. The patient agreed and set a date for his leaving the ward. On this date, however, he stated that he did not care to go at this time but would during the next appointment. At the next appointment he accompanied the therapist to his office in another part of the building.

As therapy progressed, it became somewhat more exploratory rather than altogether supportive.

Henry described his extreme hostility to

[2] Although the acceptance of delusionary material provides a method of sharing psychotic reality with a patient, in beginning therapy many workers still insist on "confrontation," or presenting the patient with what they consider to be "reality."

his father and brother and expressed a tolerance of his mother. Beneath this verbalization, however, there was also obvious hostility. His speech gradually became more relevant and reality-oriented. Therapist and patient would occasionally walk on the hospital grounds and on several occasions left the grounds for a visit to the community nearby. Henry explained that he had much to "catch up with" and asked to go to the patients' library, where he would sit and read back files of news magazines for hours without interruption.

Concurrently Henry began to discuss his future plans and felt he should begin a review of his previous academic work. Since the only teacher available was a woman it was considered unwise (in view of the patient's general reaction toward women) to encourage this relationship, so he undertook this study by himself.

During the next few weeks the patient was seen for daily interviews. He continued his study of mathematics, first completing his review of algebra and then undertaking to learn calculus. His reality testing became better and although he still showed many residuals of his illness he was moved to a less restricted ward.

The content of therapy at this time was also changing. The patient began to discuss more freely events in his early life and his army experiences. According to his statement, he had always tried to do everything as well as he could and had always been concerned lest he not be as perfect as possible.

Approximately six weeks later he requested permission to visit his home on a week-end pass and this was granted by his physician. Since Henry had only hospital clothing available he requested that his mother bring several specific items for his wear on pass. When he appeared ready to leave for his pass, the therapist realized that Henry had used the therapist's attire as a model.

Following his return from his initial pass, which his parents described as successful, Henry began to increase his reading and studies. He expressed his desire to enter college to study engineering. Since his symptoms were apparently undergoing remission, his physician, psychologist and social worker felt that he should not be discouraged from such a plan. Henry began to assume initiative in making arrangements for schooling, and approximately six to eight months following his first contact with the psychologist he was placed on convalescent status.

There were, however, other difficulties in Henry's readjustment. Since he had been declared "incompetent" and would be dependent on veterans' benefits to pursue his schooling, it was necessary for him to be declared "competent" before the Veterans' Administration would approve his educational plan. This evaluation was made by his physician after an interview with Henry.

On the day of registration Henry appeared for his interview and declared that he was planning to complete his studies in three years. His motivation for his work seemed intense. That evening he called his therapist to announce that he had registered in two colleges. One school offered a liberal arts program and the other offered professional engineering courses. By attending day and night he stated that he could make up some of the time he had lost while hospitalized. The anxiety of the therapeutic team was mobilized as it seemed that all previous therapeutic effort was about to be jeopardized by such an apparently grandiose plan. Since Henry discussed realistically the amount of work involved it was decided to permit him to try the program. His regular therapy continued on a twice weekly out-patient basis.

When Henry received his first quarter's reports it was found he had attained superior grades in all his subjects.

During the next two years Henry's progress in his academic work and in therapy was steady. Reality testing in everyday situations improved significantly as did his judgment. Although he was slow to initiate heterosexual and social contacts he related well to classmates and family. He continued to carry out all school responsibilities with superior achievement, and his weekly therapeutic appointments were reduced in frequency to bi-monthly intervals.

When it became necessary for his therapist to leave the city for another position, Henry had not completed his schooling. It was decided to leave with him the decision of continuing regular therapy. Henry felt that he did not wish further treatment at this time.

FOLLOW-UP

About a year later the therapist received a graduation announcement from Henry, followed by a letter stating that he had accepted a position with a well known manufacturer of electronic equipment making it necessary for him to leave the city. Shortly after, another letter gave details of his contemplated marriage.

Over the 8-year period following his hospitalization Henry has attained a responsible professional position as an engineer with his firm, in which he contributes at a creative level in the design and development of electronic equipment. He has become the father of two sons and his marriage adjustment seems secure.

During these years he has maintained contact with his therapist by letter but the nature of the relationship has changed. During the period in which Henry was undergoing intensive treatment he never referred to his therapist by name. His early letters were addressed to "Mr," but about a year following his therapist's departure he began his letter with the salutation "Dear Joe," and then stated: "I believe that by this time I should call you Joe since we have been through so much together." His letters now are relatively infrequent but usually contain news of his job, family and plans for the future.

CONCLUSIONS

With patients whose illness precludes verbal communication in beginning treatment sessions, it is difficult to formulate specific dynamics except in a highly speculative vein. There are, however, some principles of therapy whose application seems to facilitate the formation of a relationship with acute or chronically disturbed patients. They were found helpful in Henry's treatment. Among the more relevant of these principles are the following:

- Before a therapeutic relationship can be established some degree of communication must be achieved, and the therapist initially must provide most of this stimulation.

- It seems less important to "confront" the patient with his delusional material than to accept this material temporarily with the objective of furthering the relationship.

- Although the therapist is perhaps a chief mediator of "reality" to the patient, this role should be subordinated to that of providing adequate support for the patient during early phases of treatment.

- Interpretation of unconscious material in beginning treatment interviews seems to be less important than the therapist's understanding of the patient's total situation.

- Motivation of the therapist should be consistent and should reflect his conviction that the patient can and will be helped. With the schizophrenic patient this conviction may be communicated in several ways.

- "Institutional stereotypes" should not deter the therapist if in his judgment the patient presents assets for treatment.

- Status differences between therapist and patient should be minimized and the relationship should be essentially a "sharing" one in which therapist and patient are working together toward the same goal.

Henry's illness and successful reintegration, while dramatic, is not unique. Many psychotherapists have had similar experiences. Neither does Henry's case history provide precise scientific data useful in constructing theories as to the nature of schizophrenia or the schizophrenias. It does reemphasize the fact that if sufficient psychotherapists were available many patients now considered "hopeless" would have the opportunity for adequate psychotherapy and return to society.

COMMENT BY MARGARET CROSSEN, M.S.W.

Henry's mother first became known to this social worker when she was sent by the ward doctor to talk about her son. The mother had seen another worker and given a rather factual social history at the time of Henry's admission to the hospital. There had been no further dealings with her until April 1947. She was referred because her behavior was so upsetting to ward personnel. At each of her three weekly visits it was the mother's practice to bring huge quantities of food, including a large cake, a quart of ice cream, cookies and sometimes candy. These she would feed to the patient, who consumed all in one sitting and ate nothing until her next visit. It was also her practice to seek out the ward doctor in the futile hope that she could convince him that her son's condition was of organic etiology, and therefore greatly more hopeful.

Mrs. J welcomed an opportunity to talk about Henry, describing her fears about the hopelessness of his case, and about her need to do something active to help him. She was given great approval for her wish to help her son and encouraged to think of herself as part of the hospital team. After four interviews she could herself suggest that she was able to see how the food she was bringing made it hard for her son to have a proper diet. She was helped to anticipate the hostility the patient would display when she cut down on this, but with considerable support was able to follow through. She was seen weekly for ten weeks to give her a chance to become identified with the hospital's treatment program and to talk about her feelings about her son's illness. After this she was seen monthly to sustain the gains made earlier.

When Henry's therapist was able to establish rapport and Henry began to show interest in getting well, a conference was held in January 1948 in which the team members shared thinking about the case and defined areas of functioning. It was agreed that the therapist would follow a passive, permissive non-demanding role, which was the one to which Henry was able to relate. The social worker would see the mother to get her involved in the treatment plan and to help her to cooperate with it by giving her interpretation and anticipating ways in which she might reinforce the therapeutic effort. The psychiatrist would give guidance to the total plan and supervise the psychotherapy.

The mother responded to Henry's improvement with excessive enthusiasm and with a resurgence of her tendency to become quite active in pushing for progress. She began to think and plan far beyond the patient's level. She was encouraged to talk about each aspect of Henry's progress in the effort to help her to see it as it really was. She was given strong encouragement to control her own strivings and to let the patient progress at his own rate.

In treatment the patient became quite hostile to his parents and to the hospital personnel in authoritative roles. Mrs. J felt this keenly and began to interpret it as a setback. She was allowed to talk about how Henry's anger was intolerable to her, was enabled to see that this episode extended beyond the relationship with her, and was given some interpretation of how the therapist felt about this hostility. It was interesting to note the way in which it was possible for Mrs. J to identify with the therapist's thinking and to modify her own along these lines.

Another team conference was called in March 1948 when Henry was ready to move from the closed ward. The plan, an irregular one, was to allow Henry to leave the closed ward during the day and to return at night. There was a great deal of opposition by hospital personnel both because of the irregularity of the plan and also because Henry was by then considered with less optimism than that shared by the team. The therapist interpreted the patient's need and enlisted the cooperation of other hospital personnel, and the psychiatrist and social worker backed up this interpretation.

When Henry came to the open ward his first request was to discontinue his mother's visits. This was hard for Mrs. J, who saw this as cutting her off from participation in her son's recovery. She reluctantly accepted the recommendation as important in the whole treatment plan, and agreed to a procedure by which she could telephone the social worker at regular intervals to learn about Henry's progress and to talk about her concerns. After Mrs. J stopped visiting, Henry began to seek out the social worker to convey messages to his family and to talk about some of his plans for the future.

In June 1948 Henry was given a pass to go home for the week-end. The family described his adjustment in glowing terms, and the plan for passes was continued. Later the mother became more realistic about Henry's adjustment and began to report his adjustment and her observations in such a way as to be more useful in evaluating Henry's progress. During this period Henry made many unrealistic demands on all members of his family, and particularly on his mother. She was aware that her impulse to grant his every wish was not helpful to him, and was responsive to direct suggestions and encouragement in this area. Henry's readiness to accept limitations was in itself helpful to Mrs. J in dealing more realistically with her son.

In August 1948, after Henry had made suitable plans for school and had become greatly more comfortable socially, plans were made for a trial visit from the hospital. It was arranged that he would continue to see his therapist on an out-patient basis and his mother would continue to work with the social worker. From this point on Mrs. J reported steady progress in social adjustment. Henry became involved in his school work, decreased his demands on the family, began to reach out in social relationships, and was able to tolerate two disappointments rather well. The focus with Mrs. J was to help her to permit Henry to move away from her. Fortunately, her conscious wish for Henry's recovery was stronger than her need to keep him dependent upon her. She sought the

help of the social worker on each occasion when Henry seemed to be moving to a more independent level of adjustment. At these times she was helped to see such movement as representing progress, and given recognition for her part in it. Except for an occasional card at Christmas, Mrs. J has not been in touch with the social worker since 1951.

In retrospect, this worker thinks of Henry's recovery as intimately related to two factors: the therapist's respect for Henry and the genuine optimism he felt about Henry's capacity for improvement, and the strength of the mother's conscious wish for Henry's recovery, which took precedence over her unconscious impulse to infantilize him and to prolong the satisfactions she derived from this role.

COMMENT BY ALFRED G. GREEN, M.D.

My remarks on this paper will necessarily be more general than specific.

There are several points that stand out in this report. One is the obsessive-compulsive personality pattern of the patient and how this was played into in a negative way by his first therapist. Particularly is this true when the therapist remarks that he "wasn't going to pay much attention to the patient." This statement sounds as if he were going to treat Henry in a spiteful way. At another time he seemed to take over control of the entire situation when he said that he was going to determine when and how discharge from the hospital would be effected.

At this point one must also question why the patient was so obstinate. Of course, Henry had obsessive-compulsive traits but this does not explain it dynamically. Whether he had a father who was greatly authoritarian, we do not know. It might be significant, however, that Henry had his breakdown in a German prison camp. Undoubtedly there he was treated in the traditional Prussian manner. How much this may have contributed to the precipitation of his psychosis is not clear but undoubtedly it is important. In this connection it might also be noted that Henry was an officer in the Air Corps, where a great deal of discipline during his cadet training was demanded from the patient.

There was also a previous incident in which Henry's pilot was killed. As Henry was the co-pilot, this may have been important from the standpoint of his having to control everything in the therapeutic situation. Many people who have worked intensively with psychotic patients report that the catatonic defense protects against the expression of a very primitive destructive rage. This need to control the situation would be, then, an important mechanism in re-enforcing the catatonia and later in the course of therapy would allow the patient to use this mechanism as a temporary crutch while giving up the catatonic posture.

When his second therapist saw Henry he apparently made a much different impression. Contributing to this impression was the new therapist's willingness to accept Henry with all his delusions and eccentricities. This would of course include the patient's need to control the situation. It is also apparent that his second therapist developed with Henry the understanding that his need for control must be kept within bounds. Perhaps the most important point was that no issue was made of this. With the former therapist Henry obviously felt he had to "test this out" before he could really relate to him. He tested him, found him wanting in that respect and could not give up his more regressive

psychotic patterns. He apparently found his second therapist more flexible and thus was able to make the first all-important therapeutic step.

In the above connection Miss Crossen's work with the mother was of paramount importance. As Henry's relationship became stronger with his therapist, his social worker weaned the mother away from the patient. Thus the conflict about separation from the mother was kept at the lowest point possible, while the relationship with his therapist was growing. His therapist bought him soft drinks from the canteen. This "feeding," we may conjecture, was important at this time, but his new therapist gradually weaned him. This appears to have been a substitute for the feeding, yet restrictive and compelling, relationship which his mother offered him when she brought Henry ice cream and layer cakes. She felt she had to do something to "almost force" him to get better. To put it another way, with his therapist, he could receive oral gratification without excessive restrictiveness.

In summary, it seems that Henry's first therapist failed to accomplish the initial step in any psychotherapeutic approach, *i.e.*, the establishment of a relationship through which therapy can proceed. This resulted in an impasse with patient and therapist struggling for control, the therapist finally rejecting the patient and the patient maintaining his psychotic defense.

His second therapist was able to effect a non-threatening relationship, and one in which there was acceptance by the patient of some reality limits. At this time the social worker was relieving the patient of the demands of an over-controlling mother. She was also helping the mother toward some insight into her role in Henry's illness. Other ward personnel played an important role in Henry's remission as soon as they could overcome their previous ideas about him.

Henry's post-illness record is unusual, and worthy of particular emphasis. Although this patient was seen at a time when the "team approach" concept had not gained its present wide use, this case record provides a demonstration of its possibilities.

DAVID LANDY, PH.D.
WILMOT D. GRIFFITH, M.A.

Employer receptivity toward hiring psychiatric patients

With the advent of tranquilizing drugs and new methods of social (or milieu) therapy in mental hospitals, the probability of patients being discharged has increased markedly during the last several years. More difficult than hospital treatment of the mentally ill, however, is that part of the rehabilitative process which occurs after the patient leaves the hospital. For many patients, especially those who depend upon themselves for a living or have to provide a livelihood for others, the prediction of successful rehabilitation depends to a large degree upon their occupational success. Naturally a crucial factor is whether an employer in the community, if he knows a prospective employee has been a psychiatric patient, will be receptive to hiring him and assisting him in making the necessary adjustments to happy and productive work.

Traditionally vocational counselors and social workers have assumed that the psychiatric patient will succeed in the world of work only if he possesses enough confidence and ego resources to seek and find a job on his own, and only rarely have they even suggested where to look for employment. Many of them claim that "leading the patient by the hand" not only prolongs his dependency but almost guarantees that the employer will have little confidence in the individual's ability to function independently, and therefore almost certainly dooms the outcome. However, systematic research into this customary handling of the problem as well as experimentation on the possibility of lending more direct assistance to very dependent patients has been almost completely neglected. Furthermore, little has been done to contact employers in the community, to "sell" them on the feasibility of employing former patients, and on the basis of previously determined

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receptivity of employers to attempt placement of former patients with them. Recently these approaches to the problem took place at the Massachusetts Mental Health Center (Boston Psychopathic Hospital) as part of a demonstration and research project, Rehabilitation of the Mentally Ill, sponsored by the Office of Vocational Rehabilitation, U. S. Department of Health, Education and Welfare.

During the course of attempting to place convalescent or discharged patients in employment in Boston and the surrounding communities the vocational placement counselor of the rehabilitation project at the Massachusetts Mental Health Center interviewed a series of employers representing a wide variety of businesses and occupations. In each instance the employer was asked about present and past policies with regard to hiring patients or former patients of psychiatric hospitals and was given a proposal concerning the feasibility of using employees with current or past behavior disabilities.[1]

It was decided *ex post facto* to review and analyze this very necessary stage in the rehabilitation process with the first 52 employers in the series. It should be emphasized, however, that this procedure of actual job placement is a necessary stage in the rehabilitation process for only a minority of discharged psychotic or psychoneurotic patients. While the hospital has not yet compiled statistics on this factor, it is probable that our experience is not essentially different from that of the extensive study of hospitals in three eastern states where it was found that ". . . only 15% of the patients who leave the hospital improved or recovered from their illness need professional help in securing appropriate and satisfying employment."[2] Even this small proportion may not need the direct kind of assistance involved in actual job placement provided they have received adequate counseling and psychological support.

The 52 employers ranged in size from large firms employing hundreds and thousands of persons to small businesses using only one or a few employees. The types of establishments were grouped as follows in decreasing order of frequency: 13 manufacturers, 12 hospital and nursing homes, 5 services (such as filling stations), 4 educational institutions (libraries, museums), 4 small stores, 4 department stores and supermarkets, 2 health agencies, 2 horticultural nurseries, and a law firm, an insurance company, a restaurant, an advertising agency, a bank and a mail order firm.

Types of occupations for which these 52 employers considered the possible use of former patients were in the following decreasing order of frequency (they are multiple coded; the total is therefore greater than 52): 27 clerical, 13 sales, 8 production, 4 medical aid, 6 distribution, 6 service and maintenance, 4 nurse's aid, 3 engineering, 2 mechanical, 2 nurseryman, and 1 each dance instructor, copywriter and construction worker.

We have no way of knowing how representative this is of the range of employers or types of occupations in the area, nor is it a random sample since the population is not known. The placement counselor in

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[1] In about one out of five visits the counselor was accompanied by a student nurse. This was considered part of her training in the rehabilitation aspects of psychiatric nursing, but was entirely voluntary on her part. In each instance the student found the trip helpful as a training device; in two cases, the experience helped to overcome the students' own conflicts concerned with future problems of job placement and fears of personnel interviews.

[2] Thomas A. C. Rennie, Temple Burling and Luther E. Woodward, *Vocational Rehabilitation of Psychiatric Patients*, New York, Commonwealth Fund, 1950, 20–21.

TABLE 1

Receptivity of 50 metropolitan Boston employers toward a proposal to hire emotionally handicapped persons

RATING	TYPE OF ATTITUDE REPRESENTED	TOTAL
4	Very receptive, enthusiastic, almost altruistic	12
3	Receptive, friendly; or willing to employ an individual regardless of a history of illness	28
2	Slightly receptive but doubtful, hedging	8
1	Very unreceptive, antagonistic, uninterested	4
	Total	52

several instances either knew the employer or singled out the firm on the assumption that it could provide the possibility of a job congenial to specific patients the counselor had in mind. We do feel there is sufficient diversity of type of business and range of occupations to offer a partial sampling of employment possibilities for patients or former patients in this area.

Of these 52 employers in metropolitan Boston 16 had had previous experience in the use of emotionally handicapped persons. All but two of these 16 had positive attitudes toward such persons as employees. When approached with a proposal to employ current or past psychiatric patients, 77% of the total sample were highly receptive (3 or 4 on our scale of receptivity) to the idea (see Table 1), the mean of the 4-point scale of receptivity to the proposal being 2.9.[3]

It will be helpful to illustrate the scale with examples of employers who fall in each of the rating categories:

4. Very receptive. An example is seen in the manager of a business machine company, in whose family there had been a case of mental illness. He had never hired an ex-mental patient before but was almost anxious to do so. When the opportunity to place a secretary with him presented itself he made the position available to her as his personal secretary, and related to her in a friendly and accepting manner.

[3] The two authors, one of whom did the actual interviewing, independently rated each employer on the scale. Because some of the write-ups of the interviews were characterized by a paucity of data, it was decided to count any difference of judgment, even on scale point, as a disagreement, rather than to assume a range of one point above or below each judge's rating, as is frequently done in studies involving behavior ratings. As a statistical measure of agreement we decided on the chi coefficient of association ($\phi = \sqrt{\frac{\chi^2}{N}}$), which can be derived easily from chi-square, as the formula indicates. For this suggestion we are indebted to Alberto DiMascio of the research department of the Massachusetts Mental Health Center. It has the advantage that while it is a product moment correlation it makes no assumption about the shape of the distribution, and thus fits the needs of working with a skewed sample. Even with our stringent criterion for agreement, we found a ϕ value of .276 between our ratings, which is significant at the .05 level of probability.

3. Receptive. Only a little less positive was the attitude expressed by the employment manager of a museum who had had previous experience in using ex-mental patients. His criterion seemed to be that if a man was careful and dependable his past illness need not stand in his way, and ability to do his job was unprejudiced by former status as a mental patient. This employer subsequently hired one of our discharged patients, who is still working for him.

2. Slightly receptive. The attitude of a large supermarket seems typical. This business has a policy whereby ex-mental patients and physically handicapped persons are occasionally hired on a part-time basis. Full-time employment for known ex-mental patients is not generally considered to be profitable for the company, since health and accident insurance premiums may increase if the general practice is followed. However, part-time employment is not affected by these restrictions, although it is not accompanied by benefits which accrue to full-time personnel. A dramatic example of the employer's policy is seen in the case of a relative of the owner of this market who was turned down in his application for a job after his discharge, which he assumed had been promised to him previous to his hospitalization. He was told that he could apply for part-time work but that there was no position on the full-time staff for which he could be considered.

1. Unreceptive. This classification is exemplified by the owner of a flower shop. This employer was brusque and said that his help came from schools and that he did not need more employees at the time of interview. He indicated no interest in what the counselor had to say and continued to wait on customers while the latter was talking.

A total of 26 employers changed their minds to some degree as a result of this "public relations" interview. Nineteen of these changed to a definitely positive attitude (3 or 4 on the receptivity scale) from a previously negative one. Seven changed only slightly from a negative to a mildly receptive but highly qualified attitude (rating of 2). Four employers who previously had a negative attitude remained in this frame of mind. A total of 22 with previously positive attitudes retained them after contact with our counselor; no employer with a previously positive attitude was moved to change his outlook negatively after speaking with the counselor.

But how could we be sure that the apparently receptive employers would implement their attitudes when presented with the opportunity to employ present or former patients? The process of hiring emotionally handicapped persons is exceedingly complex and the final answers will not be easy to come by.[4]

Certain immediate components of decision-making and outcome of attempts to place psychiatrically disabled persons with employers seem obvious. One is the employer's ability to utilize the services of those whose life history may include a period of emotional disturbance. Another consists of the state of physical and psychological health of these employees and their ability to engage in pursuits productive of remuneration and satisfaction for themselves and profit to the employer. A third is the ability of the referring agency—hospital, clinic, state rehabilitation service and so on—to assess properly the prospective employee's state of mental health and tolerance for work and to determine his readi-

[4] Cf. C. H. Patterson, "Rehabilitation Counseling of the Emotionally Disabled," *Journal of Counseling Psychology*, 4(4, 1955), 264–70.

TABLE 2

Outcome and method of counselor assistance in 59 attempts to place 33 patients among 29 employers

OUTCOME	ACCOMPANIED BY COUNSELOR TO JOB INTERVIEW	COUNSELOR MADE APPOINTMENT BUT DID NOT ACCOMPANY	COUNSELOR MADE SUGGESTIONS; GAVE NO FURTHER AID	TOTAL
Unacceptable to employer	10	9	–	19
Hired but refused job	11	3	–	14
Acceptable to employer but no job available	3	1	–	4
Employer hired but reneged	1	–	–	1
Did not keep interview appointment	–	1	–	1
Obtained job; held for some time	9 •	8	3	20
Total	34	22	3	59

• Includes two attempts for 1 patient, one attempt lasting less than three months, one more. In various comparisons, this is counted as one job lasting more than three months, thus yielding a total of 19 rather than 20 for the category.

ness for the specific occupational role being contemplated. This latter factor—frequently the job of the vocational counselor, clinical psychologist or social worker—is perhaps the most difficult of the three and obviously basic to the success of any rehabilitation effort.[5]

Problems involved in this complex and delicate procedure are in the forefront of research endeavors in the field of vocational rehabilitation. We shall present certain partial data as to the outcome of placement attempts with the employers considered in this study. A fuller statistical analysis is the subject of a parallel study.[6]

We have attempted to place 33 persons with a history of mental illness with 29 of the 52 employers in this study. A total of 59 placement attempts were made for the group. Nine of these firms rated 4 on our scale of receptivity, 15 rated 3, 5 rated 2. The mean scale score for the group of 29 employers with whom placement was attempted was 3.1.

Each of the persons for whom placement was attempted was the recipient of some type of counselor assistance, as can be seen in Table 2. In addition to the 19 who managed to get jobs as a result of this assistance, 9 others obtained jobs completely on their own, about half with employers

[5] Morton A. Seidenfeld et al., "The Evaluation of Rehabilitation in the Individual," *American Journal of Orthopsychiatry*, 27(1, 1957).

[6] David Landy and Wilmot D. Griffith, "Occupational Placement of Patients from a Mental Hospital," (to be published), 1957.

in the sample. These became subsequently known to the counselor. Undoubtedly a large proportion of others also eventually obtained jobs on their own, but since a systematic follow-up procedure has not yet been instituted there is no way of knowing this accurately. It is worth noting that in each of these 9 cases of independent self-placement, attempts to assist directly with placement had not materialized, but these patients had sufficient ego-strength eventually to attempt the weaning away from the hospital. With these 9 a total of 13 previous attempts had been made, ending in no employment either because the prospective employee was unacceptable to the employer (9), was hired but failed to take the position (1), or was acceptable but no job was available at the time (3).

In 8 instances the persons placed quit within a relatively short time after taking the job, their time on the job varying from one day to a few weeks. In each case there is evidence that the placements were premature, since the person was either too ill to be expected to work in a normal situation or his capabilities and interests were not matched to the particular work situation. For example, a patient still feeling the effects of a paranoid schizophrenic psychosis was placed on a direct selling job; this kind of situation, where the young man had to work against odds to convince potential customers of the wisdom of buying an encyclopedia, was not conducive to his feelings that he had to beware of the intentions of people, and a series of refusals to buy his product would undoubtedly reinforce his delusions of persecution. After two frustrating weeks on a drawing account he left the job.

One employer who had agreed to hire a particular patient got "cold feet" before the patient arrived on the job and canceled the employment without seeing the prospective employee. An additional case of premature placement involved a young woman who had a psychotic break after being on the job for a few weeks. However, after a brief period of rehospitalization she was placed on another job where she has been functioning successfully for several months. Thus one way of looking at the first placement may be as a period of further tolerance-building for the patient.

This last case is part of a total of 11 where the person placed has worked a minimum of three months. Here we may speak of having achieved relatively "successful" placements. Eight of these actually worked considerably longer than three months and were on the job when this survey was originally made (March 1957).[7] After a successful placement of three months, 2 of the re-

[7] These are in addition to 7 of the 9 who placed themselves independently and who remained on the job at least three months. Thus a total of 18—or more than half of the 33 persons for whom placement was attempted at some time—achieved a certain degree of post-hospital occupational stability, as measured by length of time over three months on the job. Of course, what we do not know, as mentioned above, is the extent to which patients of whom the hospital has lost track have been able to achieve vocational success. It would seem likely that the probability is good that some of these will be able to achieve some degree of occupational status and stability independently of the assistance of counselor, psychiatrist, social worker and others. Studies such as that of Rennie, Burling and Woodward, *op cit.*, would seem to indicate such a probability. See also J. Sanbourne Bockoven, Anna R. Pandiscio and Harry C. Solomon, "Social Adjustment of Patients in the Community Three Years after Commitment to the Boston Psychopathic Hospital," *Mental Hygiene*, July 1956; Jeanette G. Friend and Ernest A. Haggard, *Work Adjustment in Relation to Family Background*, Applied Psychology Monographs No. 16, Stanford University Press, 1948; and Marjorie P. Linder and David Landy, "Post-Discharge Experience and Vocational Rehabilitation Needs of Psychiatric Patients," *Mental Hygiene*, January 1958.

maining 3 left their jobs voluntarily to achieve additional training in vocational courses arranged through the State Division of Vocational Rehabilitation. The last of the 3 was a man who, although working with some success on the job was persuaded by his wife to give it up because she felt the work was too hard for him. The dominating spouse now has her husband back home where she makes him spend much time lying in bed; in this enforced invalidism she keeps him in an extremely dependent position. This kind of factor in a particular rehabilitation situation is usually beyond the reach of the rehabilitator, unless it can be arranged for the wife to be treated by a psychiatrist or psychiatric social worker.

An additional question is that of relative pay scale for rehabilitated psychiatric patients. To what extent would they receive the same pay as others doing the same work? While we did not probe far in this area 45 of the 52 employers said they would pay wages equal to that of "normal" employees. Seven felt they would want to pay less, but we do not have clear data regarding their reasons for this wage differential.

SUMMARY

A series of 52 employers representing a broad variety of business types and occupational categories in metropolitan Boston were asked to consider the possibility of hiring persons with a current or past history of emotional illness. More than three-fourths of these employers responded with definitely positive attitudes toward the proposal; their responses, rated independently by two investigators, yielded a significantly high degree of agreement, or judgment reliability. The proposal was instrumental in 26 employers changing their attitudes (19 from negative to positive, 7 from negative to slightly positive or receptive); 4 with previously negative and 22 with previously positive attitudes remained unchanged.

The attitudes of some of these employers were partially tested when the vocational placement counselor of the Massachusetts Mental Health Center attempted placement of 33 persons with 29 of these employers, all but 5 having been rated as receptive on a scale of receptivity. A total of 59 placement attempts occurred. Nineteen of the patients managed sooner or later to obtain employment with the aid of the counselor; 9 others, all of whom originally failed to obtain a job with the counselor's assistance, ventured forth on their own and successfully landed a job. In instances where no job was forthcoming, at least on the first try, the following reasons (in decreasing frequency) seem to hold: unacceptable to the employer, hired but refused job, acceptable to employer but no job available, employer hired but reneged, and failure to keep interview date (the latter two had a frequency of only 1 each).

In 8 cases persons who obtained employment quit within a 3-month period, while in 11 others they succeeded in holding the job at least three months. It is probable that others eventually obtained jobs in the post-hospital phase although this is not now known to the institution.

Only 7 of the 52 employers said they would pay less than the usual scale for work done by the psychiatrically-handicapped.

CONCLUSIONS

The high proportion of community employers receptive to the idea of employing the emotionally handicapped seems to run contrary to a generally accepted notion that they would be prone to discriminate against this large minority in our society. And evi-

dence of the genuineness of their attitudes has been seen in the willingness of a large portion of the group in our study to accept placements referred directly by a psychiatric hospital. Thus the fact of emotional illness does not necessarily carry with it an ineradicable stigma, insofar as the vocational world is concerned.

On the other hand, it should be remembered that patients who need help in direct placement constitute a relatively small proportion of the total population of persons discharged from mental hospitals. Recent research [8] has further shown that most former patients prefer not only to find jobs on their own but not to tell their employer about their previous illness, evidently considering it a handicap. Thus the majority of patients who leave mental hospitals are working in the many occupational roles in their communities with their emotional breakdown unknown to their employers. Since being accepted on a job is only the first stage of the patient's vocational comeback in the community, and he must also cope with his own feelings and those of his fellow-workers, this may be just as well. And insofar as the attempt at self-placement represents a desire of the patient to make his own way in the world and be accepted on his merits, this may be seen as a "flight into health," [9] at least as far as motivation based on common American values is concerned.

On the basis of these initial experiences in placement the counselor has altered his methods somewhat so that when a study of future placements occurs it is probable that the ratio of those he "led by the hand" to the job interview, or otherwise gave direct assistance, will tend to come down in favor of those to whom he gave more indirect counseling and served as enabler rather than "big brother."

As our project has progressed, the impact of poorly matched or premature person-job arrangements has become obvious. The reasons for this lie partially in the hospital's referral process for vocational placement and will not be discussed further here.[10] It is now realized that although ideally all referrals should be coped with successfully, not all patients are necessarily ready at the time of referral to take up their community relationships. Furthermore, it was decided that in justice to patient, employer and hospital, the reservoir of goodwill among community employers,[11] would be tapped only after the rehabilitation potential of the prospective placement indicated a realistic probability of success.

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[8] Linder and Landy, *op. cit.*

[9] This term was coined by one of the writers (D. L.) who subsequently discovered it was used independently by William E. Henry in his paper, "Psychology," in *Interrelations Between the Social Environment and Psychiatric Disorders*, New York, Milbank Memorial Fund, 1953.

[10] But it has been discussed briefly elsewhere, by Milton Greenblatt, David Landy, Robert W. Hyde and J. Sanbourne Bockoven, "Rehabilitation of the Mentally Ill: Impact of a Project upon Hospital Structure," particularly the section on the vocational placement officer and counselor, *American Journal of Psychiatry*, 114(May 1958), 986–92.

[11] Little accurate or objective information exists regarding the attitudes of employers toward hiring persons with a history of emotional illness. The present study is at best only suggestive of the many areas which need intensive scientific research. The most systematic study of employer attitudes and patient experiences known to the authors is that now being conducted by Simon Olshansky of the Joint Commission on Mental Illness and Health and Samuel Grob of the Massachusetts Association for Mental Health.

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Employers' attitudes and practices in the hiring of ex-mental patients

The prospect of improved treatment procedure for the hospitalized mentally ill, with the corresponding increase in hopes for recovery, has begun to shift our attention to the need for developing convalescent and rehabilitation procedures and facilities if this recovery is to be maintained and promoted after the patient leaves the hospital. Otherwise, the rising rate of discharge may be offset by a proportionate increase in the readmission rate.

It is generally recognized in the rehabilitation field that the proper employment or placement of the employable ex-patient constitutes an essential part of this recovery process, especially in our work-oriented culture. It is perhaps the first major link in reintegrating the ex-patient into normal community life. It is basic to both his self-acceptance and social acceptance. It symbolizes his acceptance in a productive role, that is, of contributing value to society as well as receiving some in return—a hallmark of increasing maturity. Consideration of these factors has led to a growing concern with the special problems inherent in the reemployment of the ex-mental hospital patient. These problems relate in general to two major areas:

- The limitation imposed upon the degree of employability of the ex-mental hospital patient by his own personality difficulties.
- The limitation imposed upon this degree of employability by employer attitudes and practices. This phase of our study has been designed to explore, in a systematic fashion,

Mr. Olshansky is on leave from the Massachusetts Rehabilitation Commission and is serving as research associate on rehabilitation with the Joint Commission on Mental Illness and Mental Health. He is the principal investigator for this study. Dr. Grob, a clinical psychologist, is project director for this study. He is also associate director of the Massachusetts Association for Mental Health, of which Mrs. Malamud is executive director.

the prevailing attitudes and practices in the hiring of ex-mental hospital patients as a first step in defining and coping with a recognizably difficult social as well as psychiatric problem.[1]

ORIENTATION OF THE STUDY

Prior experience with the ex-mental hospital patient in the labor market had indicated the complexity as well as the elusiveness of this area. It was anticipated that the problem of employment for this group had not reached a level of community consciousness which would render it amenable to an exclusively rational approach. Employers, in general, are not guided wholly by rational criteria in the hiring process. Consequently the central aim of this study was to inquire into the basic attitudes underlying the practices, policies and thoughts of employing groups with respect to the ex-mental hospital patient as a job applicant or employee. Though every effort was made to obtain as much relevant factual material as was available, such information was also conceived as data for unraveling deeper attitudes governing the employment process in which ex-mental hospital patients are involved on the contemporary scene. This is consistent with the views of most students of attitudes; namely, that attitudes may be manifested by either overt behavioral responses or by verbal responses. Hence both quantitative and qualitative approaches were employed in gathering and interpreting the data.

METHODOLOGY

Locus of study. The survey was conducted in the Greater Boston labor market area. The field work for the survey was accomplished for the most part between August 1956 and March 1957. It is a sizable and well diversified labor market. All of the 20 major industry groups (as defined in the Standard Industrial Classification) are represented in the area. In the distribution of employed workers between manufacturing and non-manufacturing activities Boston is a fairly representative city, although New England is one of the more heavily industrialized regions of the United States. During the period of this study the U. S. Department of Labor classified the Boston area as a class B labor market. This meant that the demand for labor in this area exceeded the supply available, creating an optimal situation for employer interviewing.

Sampling procedure. In addition, small samples of other agencies in the community involved in employer attitudes were surveyed as complementary though incidental aspects of the main problem. These included industrial physicians, public and private employment agencies, and labor unions. The sample selected for the employer population followed acceptable standards in sampling procedures. The samples used for the subsidiary groups were empirically chosen in random fashion, with no known bias operating in the selection. However, because of the less rigorous procedure followed, the smaller samples studied may not have the character of representativeness that the employer samples possess.

The total sample of employers interviewed was broken down into three sub-

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[1] This paper is an abridged report of the first phase of a field study supported by grants from the Office of Vocational Rehabilitation, Department of Health, Education and Welfare, and the Massachusetts Association for Mental Health. The complete study is available from the association, 41 Mt. Vernon St., Boston 8, Mass.

The authors gratefully acknowledge the patient guidance they received from Dr. Robert W. White, consultant for this study and chairman of the department of social relations of Harvard University.

samples: large manufacturing establishments (those normally employing more than 100 workers) small manufacturing establishments (those normally employing between 25 and 100 workers, and non-manufacturing establishments employing 25 or more workers. Each sub-sample was randomly selected from the three major categories. Employers with fewer than 25 workers were excluded, not because they are not likely sites of employment for ex-mental patients but because it was felt that they would probably have had relatively less experience than other employers with this population. A total of 200 employers were interviewed. Of these, 100 were manufacturing employers and the remaining 100, non-manufacturing employers. It was recognized that a larger proportion of manufacturing than non-manufacturing employers would be interviewed. A further arbitrary subdivision was made when the manufacturing sample was divided equally between large and small manufacturing establishments as defined above.

After the surveys had been completed it was found that the combined sub-samples of manufacturing establishments employed a total of 46,816 persons, or about 14% of the total manufacturing employees in the Greater Boston labor market area. The non-manufacturing establishments employed 39,884 workers, or about 6.1% of the total non-manufacturing employees in the area.

All information reported in this study was obtained in a face-to-face interview following a formal appointment with the employer. Some of our findings and analyses follow.

FINDINGS AND ANALYSES

Non-respondents. As anticipated, representatives of a few of the randomly selected employers refused to be interviewed. The non-respondents constituted about 13% of the sample, with the smaller manufacturing employer constituting the largest sub-group of non-respondents. Whether the number of refusals is small or large is difficult to say, since there is no generally acceptable norm against which to measure it. However, there was no discernible relationship between a willingness to talk and answer questions and a willingness to hire.

Employees reported hospitalized for mental illness in the last five years. For the five years covered by our survey the 200 employers reported a total of 123 workers who had been, to their knowledge, hospitalized for mental illness. Fewer than a third of interviewed employers reported these hospitalizations; or, stated in another way, more than two-thirds of the employers had no knowledge of any of their workers being hospitalized during a 5-year period. Since there was a considerable turnover during the 5-year period, the total number of workers representing the population from which this 123 are drawn would be substantially in excess of the 87,000 workers employed during the time of survey.

Reemployment of hospitalized employees. Almost 70% of hospitalized workers were reemployed after their discharge. Only a small number were refused employment. Another group had not reapplied or were deemed "not ready" for work.

It seems clear that almost all employers are willing to rehire their *own* workers after a period of hospitalization. This suggests that employers tend to have a more accepting attitude toward their own employees with a history of mental illness than toward the job applicant with a similar history.

Employers' hiring policies and practices. As a matter of general policy 153 employers, or about 75% of the sample, stated that they would hire ex-mental patients; 47 employers, or about 25%, stated that they

would not consider any ex-mental patient for employment.

However, only 27 employers, or about 13% of the sample, did hire knowingly any former patient during a 3-year period. The number hired was 58. Of the 27 hiring employers, 22 hired 45 of the 58. Four employers made more than a quarter of the hires. With the exception of these four non-manufacturing employers having a work force between 500 and 1,000, non-manufacturing employers made only 11 other hires, and most of these were by the smaller employers. Among manufacturing firms, almost 70% of the hires were by smaller employers.

In short, both in relative and in absolute terms the number of reported hires is small and concentrated among few employers.

Though we do not know how many qualified ex-mental patients applied for work and were rejected because of their history of mental illness, the paucity of hires suggests that employers prefer not to hire known ex-mental patients. Further evidence of that preference is that only 5 employers interviewed expressed a willingness to consider hiring any qualified ex-mental patients interested in immediate employment.

It should be borne in mind that the hiring process generally is not always a rational one and that criteria other than job qualifications are often considered. Religion, age, race, anatomical and systemic normality, sex and "personality" are some factors not always relevant to job efficiency yet often included, explicitly or implicitly, in the criteria for hiring.

A history of mental illness is thus another factor which may affect a person's job opportunities. The tendency of employers [2] to exclude groups—such as those over 45 or those with cardiac disease or Negroes—places the individuals in these groups at a marked disadvantage as they have no control over the ascription of group qualities to themselves as individuals.

Within the setting of the labor market, having a choice of hiring non-disabled workers or workers with a history of mental illness, the employer—whatever his personal preferences may be—is likely to avoid those whose work capacity is in question. There is the often expressed hope among rehabilitation workers that employers can be educated to function as quasi-therapists. The data of this study suggest that such an outcome is not likely. Employers conceive their role to be that of maximizing the efficiency of their work force, not that of quasi-therapists. Moreover, it can be argued that the non-judgmental and accepting attitudes characteristic of a clinical setting are not appropriate to a work setting.

Employer attitudes toward mental illness. What were employers' basic attitudes toward mental illness? The following picture emerged from the data.

Of the 200 employers almost half revealed much concern with violence, in the form of ex-patients being destructive either to themselves or to others. About the same proportion were concerned with recurrence of illness. Though many employers talked about the fact that mental illness is curable, apparently they have deep doubts about this. A third factor of great concern to them was the ex-mental patient's tolerance threshold for pressure and speed; they left unanswered, however, the question of how appropriate amounts of pressure and speed might be measured.

Incompatibility was another factor of importance for 66 employers. Sixty-one ex-

[2] It is relevant to point out that the U. S. Civil Service Commission requires a post-hospital convalescence of one year before considering an ex-mental patient eligible for employment.

pressed anxiety about "acting out" (expressed as "fly off the handle," "blow up," "flare up").

Bizarre behavior was expected by 30 employers. The words they used to characterize bizarre behavior were "queer," "peculiar," "strange."

A significant minority compared an ex-mental patient to Negroes and convicts. Some employers identified mental illness with immorality; sex perversions and stealing were the two most frequently ascribed immoralities. A small minority equated mental illness with mental deficiency.

Thus it can be seen why close supervision is thought to be needed: "anything can happen," "you can trigger off a relapse," "you have to watch them like a hawk" or "treat them with kid gloves." Considering the quantity of anxiety expressed, it is indeed remarkable that three-fourths of the employers are willing to hire as a matter of stated principle.

Jobs available for ex-mental patients. About 30% of employers said they would place ex-mental patients in any job for which they qualified. This response represents a constructive attitude. On the other hand, more than 40% said they would consider former patients for only certain types of jobs. Suitable jobs named were unskilled jobs—simple repetitive ones such as typing and filing, service jobs such as porter and janitor. Employers would avoid sales jobs or any job requiring contact with the public, "pressure" jobs, "responsible" jobs, supervisory jobs, "hazardous" jobs and "difficult" jobs.

Given the anxieties of employers regarding the propensity of ex-mental patients toward violence and "acting out," their inability to tolerate pressure and speed, and their alleged "incompatibility," we can understand the employers' tendency to channel ex-mental patients into unskilled and service jobs characterized by minimal interpersonal contacts, low requirements both qualitatively and quantitatively, and few opportunities for promotion. In addition, during a period of full employment these are the jobs most difficult to fill. It is interesting to note that these are the same kinds of jobs offered to Negroes and ex-convicts. Lastly, these jobs are unimportant ones, so that in the event of the expected relapses no money has been wasted in training. Basically, these jobs are considered to be relatively comfortable, free of pressures, and simple enough for a "sick mind" to do. They are jobs with such permissiveness that the employer can even tolerate bizarre behavior by the worker.

An added reason for considering ex-mental patients for such jobs follows the inevitable process of grouping all ex-mental patients into one undifferentiated category. One first invests them all with common traits and then one limits them to certain jobs because of these alleged common traits.

In the light of the undifferentiated picture of ex-mental patients and in the light of employer anxieties and fears regarding them, it is not hard to see the reluctance of employers to hire them, and to hire them if at all for only those jobs marginal workers have traditionally done: jobs paying low wages and offering little opportunity to move upward.

One point in partial justification of the employers' practice of assigning ex-mental patients to unskilled and service jobs is that not infrequently these are the jobs ex-mental patients apply for. Putting a low valuation on themselves, and often without vocational guidance and direction, they may apply for low-level jobs. In some cases such jobs are appropriate and suitable, either as terminal or beginning jobs; that is, the residuals of their illness may

limit their vocational capacities for varying periods of time.

Patterns of employing ex-mental patients. The two preferred channels of employment were hiring "at the gate" and hiring from the mental hospital. In fact, almost 40% of all large manufacturing firms preferred hiring from hospitals. This preference offers hospitals an opportunity to explore and develop further employer contacts. The preference of only 14 employers for hiring from employment agencies suggests perhaps that too much reliance has been placed on them by rehabilitation personnel to the detriment of the ex-mental patient.

The expressed preference for hiring from hospitals is understandable in terms of the employers' stated need for medical information and assurance, doctor's recommendation, and hospital records.

Regarding the common practice of accompanying patients, 142 employers expressed a preference for talking to the patient directly and alone. Only a very small minority—12 employers in all—expressed an interest in having the patient accompanied by a second person. Why this strong and frequently stated preference? First, some employers felt a second person would inhibit their talking with the patient. Second, it was stated that the situation would arouse the curiosity of other workers. Third—and most important for many employers—coming alone, standing on one's own feet and speaking for oneself would be significant evidence that the patient has recovered enough to be able to work. Contrariwise, the need to have a second person would suggest a lack of readiness to undertake regular employment. "If he cannot come alone, I don't want him" was the way many employers put it. Fourth, some employers were afraid a second person would exert pressure to compel their acceptance of the ex-mental patient.

It should not be inferred from what has been said that ex-mental patients do not need help in determining appropriate vocational goals, in developing interviewing techniques, in locating possible sites for employment and in reviewing their experiences in job-finding. Moreover, it should be recognized that for some patients a more aggressive, paternalistic kind of help might be necessary to facilitate their employment.

Some further results of having patients apply for work unescorted, besides enhancing their chances of employment, in many instances, would be that hospitals would be compelled to select them more carefully before permitting them to enter the labor market; patients, after finding their own jobs, would tend to continue on them longer; and employers, after hiring ex-mental patients, would be more willing to accept responsibility for the consequences of their own choices. Finally, the procedure would help solve (at least partially) the problem of testing a patient's willingness to work and his readiness for it.

Information required by employers for hiring. Employers show a vagueness regarding the information considered desirable for evaluating an ex-mental patient's readiness for work. It was not at all clear why 61 employers asked for diagnoses, yet only 5 employers said they would use them to determine readiness. One may also ask the value, for lay groups of a diagnostic label, especially when not intended as a criterion of readiness.

Thirty-five employers asked for a doctor's recommendation, yet 84 said they would use it to determine work readiness. It is not clear why so few asked for information so many intended to use. Nor is it clear what employers meant by a doctor's recommendation. Do they want assurances that recovery is complete and the patient is qualified for a given job? Fifty-one asked

for hospital records, although 65 said they would use them in evaluating readiness. Again it was not clear just what part of the record they wanted, or could interpret constructively. What do employers mean by hospital records?

The vagueness and disparity expressed in these matters suggest that employers have probably not thought through the process of evaluating ex-mental patients, since for many of them the situation has occurred infrequently or not at all. It cannot be overlooked that in some instances requests for medical data may reflect underlying resistance on the part of the employer.

Although only 33 employers said that the interview would be a criterion of hiring, it would seem likely to be more important than other factors cited more frequently. Whatever a doctor may say or a hospital record show, an employer is going to be more influenced by what he sees and hears. The interview is probably the most important variable in the process of determining readiness for work. It is unfortunate that some patients may be adversely judged in an interview, despite a capacity for work.

Seventeen of 50 small manufacturing employers, 6 of 50 large manufacturing employers and 7 of 100 non-manufacturing employers said they would employ on a trial basis. For small employers it was the most frequent response. This may suggest why small employers are more likely to hire an ex-mental patient than other employers, since a job try-out (assuming it is long enough and under reasonably good conditions) is still the best way of determining readiness for work. In fact, for many patients it is perhaps the only way. Some moderately disturbed patients, despite their impairment, can and do function effectively on a job. However, this fact can often be established only by a try-out.

Telling fellow workers. More than 75% of all employers would not tell fellow workers that the new employee was an ex-mental patient. The reasons given were:

- It might upset fellow workers, even to the point of causing some of them to quit.
- It is a private matter and telling would be a breach of confidence.
- Some workers would be over-sympathetic and possibly obstructive in their helpfulness.
- "Fellow workers would be cruel and would not give the patient a break." (This hostility was often ascribed to ignorance—"low class" of people in factories and "you know what human nature is.")

Points 2 and 4 were most frequently expressed.

It would seem that whatever the real reasons for employer policy on this matter at this time they are probably correct in wanting to withhold such information. In view of this, it would seem advisable for each person to exercise discretion and judgment in telling his fellow workers about himself. This is not to deny that for some patients the need to discuss their illness freely may be a strong and healthy one, but in terms of job survival disclosure of their history of mental illness may prejudice their acceptance by fellow workers. This should not be considered a moral problem but rather a practical one resulting from the stigma and stereotypes still associated with mental illness.

To test the employer's policy that it is best not to disclose a worker's history of mental illness to fellow workers, subsequent to the completion of the survey we interviewed 30 workers distributed among 4 employers in the following job classifications: 6 foremen, 6 professionals, 6 clerks, 6 skilled and 6 unskilled workers. The number

chosen to be interviewed was small because of limitations in money and time. This employee sample was diversified in order to see if attitudes were related to levels of occupation.

Interestingly enough, no conspicuous differences in attitudes were found among the workers. In some instances unskilled workers, though less sophisticated than professional workers, expressed attitudes as positive as those found among the latter.

Paradoxically, though almost all workers interviewed (28 out of 30) expressed a willingness to work alongside an ex-mental patient, and though almost all interviewees (25 out of 30) thought other workers would be willing to work with an ex-mental patient, only 4 out of 30 stated that an employer should tell fellow workers that the new employee is an ex-mental patient. And 2 of these 4 respondents were foremen. The prevailing reason for not telling seems to be that the disclosure would put the new worker on the spot and would obstruct his fitting into the group. One skilled worker expressed it as follows: "It would come back to the fellow and he'd feel on the spot as if everybody were looking at him. It would be the same for an ex-convict—if something is missing, everyone looks at him."

What has emerged from the interviews of 30 workers are the following facts: almost all workers expressed a willingness to work with an ex-mental patient and thought that other workers would feel the same way. Whether in deference to the principle that a man should be judged by what he does, or in the belief that one's illness is a private matter, or that somehow some individual workers might provoke embarrassment, almost all were opposed to the employer's telling fellow workers.

What has also emerged is that though workers' knowledge regarding mental illness may be lacking, either in completeness or accuracy, feelings toward ex-mental patients were for the most part positive. These feelings were probably based on the American principles of fair play and of giving the underdog a break.

There was no evidence within this limited study to substantiate the widespread assumption by employers that workers would be hostile to ex-mental patients. Of the workers interviewed, 26 felt that their employers should not reject ex-mental patients. The same number expressed a willingness to have ex-mental patients participate in their recreational activities.

It is suggested that the attitudes of fellow workers may not be as much of an obstacle to the hiring of ex-mental patients as is thought, though clearly a larger sampling of employee attitudes is desirable.

Employers' suggestions for increasing employment opportunities. Employers apparently have not been thinking about the problem of employment for ex-mental patients. This is not stated as a criticism. Most of them have had little, if any, direct experience with ex-mental patients as job applicants. There was therefore little point in speculating about a problem outside their range of experiences. Too, the community has not so far provided any leadership in this area, so that there exists no provocation to thinking about ex-mental patients. Actually, the employment and rehabilitation of ex-mental patients have become of concern to psychiatrically oriented agencies and persons only within the last few years. Businessmen have enough problems and urgencies of their own without going outside their area of concern or competence. And, in addition, their own problems are both immediate and pressing.

Employers frequently suggest the need for educating people about the medical ability to cure mental illness. In a sense this is a two-edged suggestion. Certainly,

considerable progress has been made in the treatment of mental illness, but to describe a person as cured is to exceed the bounds of present knowledge. Do employers want, therefore, to wait until that day comes when patients are not just improved by treatment but cured in an absolute sense?

Interestingly enough, a significant number of employers suggest the establishment of rehabilitation centers to train patients. Others recommend making more intensive placement efforts in their behalf. Both suggestions are good and worthy of further consideration, for too often patients are permitted to leave mental hospitals without appropriate vocational training or orientation regarding available job opportuinties.

Contrary to what was expected and despite the much stated fears and anxieties regarding recurrence and violence, only 4 employers recommended a reduction in liability under the Workmen's Compensation Act. The low frequency of this response is especially interesting since the Workmen's Compensation Act of Massachusetts was amended in 1945 to provide relief to employers hiring veterans who had a service-connected "mental condition" and who as a result of this condition caused an injury to a fellow employee. The lawyer who drew up this amendment informed a member of the staff that the purpose was to encourage employers to hire ex-patients who were expected to "do things." Few if any cases have come up under this amendment. The amendment also is further testimony of the prevailing attitudes toward ex-mental patients, that is, their proneness to violent behavior.

For the purpose of obtaining a more complete picture of hiring practices, 22 industrial physicians and representatives of 10 employment agencies and 10 unions were interviewed. The relevant findings will be briefly stated.

All three groups reported very limited experiences with ex-mental patients; all tended to lump them into an homogeneous mass. Both the industrial physicians and the representatives of employment agencies seemed to take their cues from employers regarding the characteristics of ex-mental patients as prospective workers. Unions, though less sophisticated, seemed willing to learn about mental illness. By and large, attitudes toward mental illness seemed to have been substantially influenced by the roles of the respondents.

SUMMARY

The most significant fact emerging from the study so far has been that employers have reported very limited experience with ex-mental patients. And perhaps almost as significant has been the fact that those employers who did report some experience with ex-mental patients did not respond differently from employers without this experience. Apparently, experience is not necessarily a good teacher. Both these facts were contrary to our expectations.

As far as can be judged, employers' attitudes toward mental illness were derived from outside the business setting and were probably in conformity with the attitudes of their friends and neighbors.

And though there was some evidence that books, magazines, newspapers, radio and television have not been without positive influence among employers on an intellectual level, there seems to have been no corresponding attitudinal changes. Thus, though a large majority of employers said that they were willing to hire, few employers actually did.

And in truth it would be incongruous to expect employers to hire ex-mental patients when they considered them to be for the most part violent, uncontrollable, and un-

predictable. What a contrast to the employers' stated need and expectation of routine and regularity! And to make matters worse, mental illness for many employers represented not only an emotional disorder but a character weakness, and in business strong character carries a high value.

Given this concept of ex-mental patients, it is little wonder that employers consider them chiefly for unskilled and unchallenging jobs—for jobs free from the requirements of pressure and speed, for jobs needing much supervision, for jobs with few contacts with other persons. In short, when ex-mental patients are hired, it is for only those marginal and undesirable jobs generally hard to fill during periods of high employment.

Therefore it should not be surprising that ex-mental patients probably tend to conceal the history of their mental illness when applying for work. It is probably this prevailing practice of concealment which explains the employers reporting limited experience with ex-mental patients. In applying for work, ex-mental patients avoid employer stereotypes by not disclosing their history of illness; employers in turn are denied an opportunity to test the adequacy and appropriateness of their stereotypes, since they hire few workers who are identified as ex-mental patients. The vicious circle is complete and self-perpetuating. Prejudice produces concealment; concealment helps maintain the prejudice.

Adding to the difficulty is the fact observed in our study that employers generally did not consider mental illness or the employment of ex-mental patients as their problem. Since their experience with ex-mental patients has been limited and will probably continue to be limited, there seems little evidence that in the future mental illness will *become* their problem. And businessmen, having more problems now than they can comfortably handle, are not likely to seek it out and *make* it their problem—and no one can rightfully expect them to do so.

Finally, all evidence within the study points up the tremendous problem of communication and the magnitude of resistance to attitudinal changes as distinguished from cognitive changes. Both experience and interest are considered necessary components to possible attitudinal changes, and both these qualities are at present lacking in this situation.

Regarding industrial physicians, the evidence suggests that they reflected, for the most part, employer attitudes, tending to fulfill in that way employer expectations.

Like employers, both unions and employment agencies reported very limited experience with and understanding of ex-mental patients. Despite this limitation, unions did manifest an interest in ex-mental patients and a willingness to help them. Employment agencies reflected employer attitudes, much as did industrial physicians, and seemed satisfied to continue their role of accommodation to employers.

CONCLUSIONS

In conclusion, the authors wish to make the following observations:

- Despite the reported prevalence of mental illness, we found in the course of this study very little evidence of significant and substantial experience with the mentally ill in a significant segment of the community—employers. Apparently, the feared and expected stigmatization has driven mental illness "underground."

- There is a need for clarifying the role of the industrial physician and employment agency with respect to this problem, so that they can function more effectively. This

might entail broadening the concept of their professional and agency responsibility respectively.

- Unions, if they are to be helpful in this area, will need more guidance, encouragement and leadership from outside their own ranks.

- There is need for further study of the attitudes of co-workers; our limited evidence of their positive attitude toward ex-mental patients suggests that they might be a source of possible support and comfort to ex-mental patients rather than an obstacle, as presently assumed, to their acceptance.

- Lastly, more comprehensive conclusions and more specific recommendations will be forthcoming at the end of our present study (now in progress) of 300 ex-mental patients. With the combined and complementary data of both studies the authors will feel more firmly grounded to formulate their views and recommendations for review and implementation.

By-products

The man who recovers from an attack of mental illness with his vocational skills intact and is then refused employment is just as disabled, vocationally, as though his intrinsic capacity for work had been totally destroyed. Long continued disuse must inevitably lead to atrophy of the skills so that he becomes in fact disabled. Perhaps more important than the loss of vocational ability as such is the loss of those vital by-products of successful employment: self-esteem, pride, ambition.—*Robert C. Hunt, M.D.,* Hudson River State Hospital, Poughkeepsie, N. Y.

JOAN FELL MURRAY

An experiment in changing the attitudes of employers toward mental illness

One of the obvious targets of the new mental health citizens' movement is employment discrimination against former patients. On the face of it, the necessary steps to diminish such discrimination would seem simple to lay out, however difficult their implementation. Obviously it is necessary to involve a hard core of employers and then enlist them in a campaign to bring our message to the wide community of employers. There are clearly a number of technical problems posed by this operation: What are effective techniques for involving these "hard core" employers and for maintaining their involvement? What are effective techniques for bringing the message in more than rhetorical fashion to a larger circle of employers? But as a group grapples month after month with these questions, often with frustration, it becomes clear that there is a basic policy question which must be answered before the technical problems can be sensibly attacked. What indeed *is* the message we want to bring to employers on this issue? You will see that this fundamental "goal" question runs as a kind of X factor, often an unseen X factor, through the history of problems that were encountered on every level in the San Francisco experiment.

I came to the San Francisco Association for Mental Health as executive director after four years as coordinator of volunteer services at Agnews State Hospital near San Jose, Calif. At this hospital, in response mainly to an unmet need that volunteers saw, we had established a rehabilitation planning committee in conjunction with a pilot program of the Office of Vocational Rehabilitation. This rehabilitation planning committee consisted of employers who met with the patient about to be discharged

Mrs. Murray, who resigned earlier this year as executive director of the San Francisco Association for Mental Health, prepared this paper for delivery at the 7th annual meeting of the National Association for Mental Health November 22, 1957, in Atlantic City, N. J.

from the hospital and actually helped the patient find a job, not only as a service to the particular patient but as an educational medium in the community. It was felt that the personal contacts made among employers in placing the patient on a job did much to destroy the anxieties they felt about hiring former patients.

When the idea of a similar committee in the San Francisco area was proposed, the San Francisco Association for Mental Health and many of the agencies [1] in the area who were concerned with the rehabilitation of the discharged patient, were enthusiastic in recognizing the possibilities for such a committee if it could begin to bring about a change in community attitude in San Francisco toward hiring former patients.

A meeting was called by the association of all agencies who might be interested and concerned. Detailed discussions followed as to how such a committee might function in San Francisco from the agencies' point of view—protection of patient privacy, sound interpretation of the problem, and cooperation among agencies to avoid duplication of effort or assumption by one agency of any other agency's responsibility.

It was agreed that the key to the seeming success of the Agnews group was the actual participation of the patient—his meeting with a group of employers. Several agencies agreed that they would attempt to locate patients just discharged and seeking jobs in the area who would appear before such a group of employers. (An important fact to remember here is that San Francisco is over an hour's travel from the nearest state hospital, and for San Francisco employers to actually interview patients at the hospitals prior to discharge was impractical and unworkable.)

Next, a group of employers from the San Jose area accepted an invitation to present a demonstration of their program before a group of San Francisco employers. Over 75 San Francisco employers, out of 100 invited, attended this meeting. An actual committee meeting with a patient was simulated. The employer (who incidentally had hired several former patients) who took the part of the patient was so convincing that many in the audience failed to realize he was not an actual patient as he talked about his fears of facing the stigma of the community in searching for a job.

At the close of the program the employers in the audience were invited to join in pioneering a similar program for San Francisco. Nine men volunteered and formed the nucleus of a committee which called itself the employment planning committee of the San Francisco Association for Mental Health. For the purpose of this paper, the details of working out committee and agency relationships, committee structure, etc., will not be described.

Suffice it to say that the first employment planning committee, which met July 8, 1955, was a group of 14 employers who stated as their goal: "To have the employer consider the former mental patient on his own merits, considering the person's ability or potential, and not arbitrarily rejecting him because he admits to having been mentally ill." A member of the industrial relations staff of one of the city's largest corporations agreed to serve as the first chairman of the committee.[2]

In a 12-month period, the committee saw

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[1] California Bureau of Vocational Rehabilitation, California Department of Employment, McAuley Clinic of St. Mary's Hospital, Langley Porter Clinic, Mt. Zion Psychiatric Clinic, Jewish Committee for Personal Services, psychiatric division of San Francisco County Hospital, Family and Children's Agency, and the Bureau of Social Work of the California Department of Mental Hygiene.

[2] Larry Loban of Crown Zellerbach Corporation.

9 patients all of whom were at the time being seen by a community social agency, most of them by the Bureau of Social Work of the Department of Mental Hygiene (the community's arm of the California Department of Mental Hygiene which provides follow-up care for patients from the state hospitals). This group of patients was a relatively sick group of people, some with complications other than a history of mental illness which affected their job situations —over age, member of a minority group, lacking in skills, etc. This is, of course, the group of patients most often seen in a social agency, since it seems to be true that the average discharged mental patient, who presents a picture of a "well" person, finds a job for himself on leaving the hospital, although he may have setbacks because of stigma. Many patients take jobs in a different area or in a lower bracket, and most do not tell about their illness and live with the anxiety of being discovered.

The committee met each month and asked one of the social agencies to provide a patient to appear at the meeting as the "educational medium." The patient was told that he would not actually get job placement help—that the purpose of this committee was to understand, and through the personal understanding of its members to gradually change the feelings throughout a community which contribute to the stigma attached to returning mental patients. The members of the committee were clear from the beginning that the committee should not serve a placement function that duplicated the function of existing employment agencies. It was understood that vocational placement involves many skills that are not known to the inexperienced person, and requires the total body of knowledge and function that are provided by the organized employment services.

A psychiatrist in private practice who had had experience in state and army hospitals was invited to serve on the committee to help answer the employers' questions about particular patients and about mental illness in general. To be able to answer questions about specific patients the psychiatrist interviewed each patient sometime prior to the meeting. A social worker from the Bureau of Social Work served as liaison chairman between the interested social agencies and the committee of employers.

The social worker from the agency from which the patient was being presented came with the patient and outlined his background to the committee. The employers on the committee decided that background information on the patient's illness should be minimal. They asked that the briefing concentrate on the work history of the patient and emphasize to the visiting employers that the particular type of mental illness or the way the patient expressed his illness should be of no more concern to them than the details of some other person's operation or physical illness.

Each month the regular members of the committee endeavored to have up to 15 other employers at a meeting. The invited employers had an opportunity to meet the patient, interview him and recognize him not as "mentally ill" but as a person who, hopefully, they themselves would like to hire. On a patient-to-employer, person-to-person basis, employers usually left the meeting enthusiastically interested in the particular patient. The employment planning committee members urged them to see all patients in this same light—and to realize that among their existing employees there were probably former mental patients who were being forced to hide the fact and were thereby causing great undue stress and anxiety on themselves and their families.

During these months of the committee's

activity there were a number of feature news stories which the committee felt served as a real aid to making it easier to get acceptance from employers of their invitation to attend these meetings. The committee also published a small brochure entitled "Would You Hire a Former Mental Patient?" which depicted two attractive, smiling secretaries on the cover with the question "which?" under the picture.

However, there were many concerns and problems expressed in and out of the meetings by regular committee members, which were usually avoided when guests were present. From the beginning of the meetings the employers and the professional persons involved faced the question of how to formulate an appeal to the employer which would interest him in hiring a patient. The employer asked: "How do we know the discharged patient makes a good employee? The professional people answered: "We don't know, but we think, based on the number who do not return to hospitals after release, that the majority must make good employees. They work and earn a living and do not return to the hospital." But the employer reacted to this statement with the argument that perhaps patients stay out of the hospitals but shift from job to job. If this was true, this was not a good employee prospect in their estimation. The social agencies admitted there were few or no statistics on this. The professional workers stated: "You may have many employees now on your staff who were patients and you just don't know about them." The employers answered: "True, but they may be our worst or best employees. We don't know." There the X factor appears in strength.

Also from the beginning of the meetings the employers on the committee expressed the feeling that they faced two other major problems:

- To find patients willing to appear before the committee (largely because already employed patients feared losing their jobs if their employer found out).

- To find patients to present before an audience of employers who came up to employer expectations.

This latter point is one that must be of real concern in any program designed to change attitudes about the mentally ill. Again the X factor rears its head. The employers expected the patients to be "well"—to show no signs of former illness and with only the problem of stigma to face. The employer found it difficult to "sell" a patient with a residual of his illness, especially since the patient's problem was often complicated because he was over age, of a minority group, or had other social problems.

The professional workers from the agencies attempted to get the lay members of the committee to see the problems of mental illness as a continuum from the slightly sick patient to the very sick and from the patient with practically no degree of illness residual to the patient with a marked degree of illness residual. Pressure from the agencies for the committee to recognize the problem in this light resulted in the employers' backing away almost entirely from assuming any personal responsibility for the placement of patients by defining the committee as "an educational medium only." In their thinking the employers separated "the patient with a disability from his illness" from the patient they wanted to work with—"the well person facing stigma." Toward the end of the year the committee preferred to find a former patient already employed and performing well who would appear before the committee. Employers emphasized that the employer must look first for production. The employers on the

committee stated: "We don't hire what we can't understand or feel reasonably sure we can predict." It was apparent that to most employers a history of mental illness meant a possible prognosis of poor job production in terms of dependability, permanency, etc.

The lay members of the committee asked again and again why no study or studies had been done that would give some answer, at least in statistics, on how a former mental patient actually compares in job performance with the average person. In the field of mental hygiene there is almost a total lack of such statistics. An exhaustive search of the literature revealed practically nothing that the committee members found of use. Much of the literature stressed that the former patient is greatly handicapped by the stigma of mental illness but investigation revealed no actual statistics or studies of the numbers of former patients or even how many formerly hospitalized patients returned to productive community living and continued same.

For this reason the employment planning committee recommended, and with the aid of a professional research committee developed, a project to gather data on such questions as how a former mental patient performs on the job, employer attitudes about hiring former mental patients, and patient attitudes about applying for a job on leaving a mental hospital. This is projected as a 3-year study, and even if funds are made readily available to carry out the study it will do only a small part of the research that is needed.

What *can* we at this point in our research say honestly to the community at large that is not only sound but acceptable to the community? We (and now I am referring in particular to the Mental Health Association) *want* to say: "You should hire former mental patients because . . ."—but how do we finish this sentence? We cannot say the former patient is a good employee judged by employer standards, because we simply do not know. The lack of knowledge available to an educational agency such as the Mental Health Association is going to be instantly reflected in any program we present, and cause anxiety in the community, in particular in a group such as the employers on the employment planning committee.

As a mental health movement we are well familiar with the need for an overall umbrella of public information. However, in promoting the employment of the former mental patient can we simply propagandize —urging "hire the former mental patient"? It seemed to the employers on our committee that such an approach as this is shielding the lack of facts which first must be made available before employers can possibly begin to accept such a slogan as realistic.

If we present a somewhat dishonest picture to the community in an effort to destroy the stigma surrounding job applicants who have had a mental illness, we run the risk of destroying the community's faith in the entire program and of not being able to take the leadership in a revised program when we know better what the real situations and needs of former mental patients are in relationship to their own abilities.

Many of the employers on the committee expressed a willingness, and felt other employers would also, to accept former patients as employees who must have help in rehabilitation, even though they might be calculated risks. But they initially wished to know whether they were accepting them as being good employment risks or poor employment risks. If the former patient *is* a poor employment risk, the employer wants to accept him as part of a community program for the benefit of the community. By so doing he will receive credit for doing a

community service in exchange for giving up some of his usually demanded productivity.

There are other complications, too. From the humanitarian standpoint we cannot make the same approach as is made in educational programs about the physically handicapped, because people feel differently about mental illness. It is not just a matter of educating the public on a subject about which they have no previous understanding. In attempting to bring about an understanding of mental illness, a vast number of misconceptions, nearly as firmly embedded culturally as religious or family feelings, must be changed.

It seemed easy for the lay members of the committee to grasp an overall concept that "one should not discriminate against the mentally ill" and to be rather eager to urge others to accept this same concept. However, the professional workers involved felt that sometimes the grasp of such a concept in reality covered only a shift in the handling of the basic feeling of fear and prejudice. In other words, an employer would sometimes indicate that he would no longer discriminate against a job applicant with a history of mental illness, but he would find some other expressed reason for not hiring the person. On the other hand, some employers, in an effort to help and overly anxious not to stigmatize such an applicant, would hire a person seemingly *because* he had been ill.

It is practically impossible in our culture today for the average employer, even with considerable knowledge of the problem of mental illness, to separate his realistic evaluation of the employability of former patients from his culturally determined feelings—some unconscious—about mental illness.

The professional workers involved in this committee program felt that in attempting to make the many illnesses and many types of illnesses understandable to the lay group they tended to over-simplify explanations to the point of rendering them meaningless. There was a frank admission on the part of the professional members of the committee, however, that in an effort to shield the employers from some of the more difficult problems or the more disturbed patients they overlooked the intelligence and perceptiveness developed by the laymen. It was not unusual to have employers raise the very points being avoided.

What has a year's experience indicated about the significance of the X factor? The series of unknowns affect a clear statement of goals for such a citizens' committee. First of all, it is clear that you cannot ignore these unknowns. If they are not dealt with head-on they will appear in hidden forms. Secondly, meeting them head-on will help such committees as the employment planning committee reach an understanding of the limits of the committee's ability to mitigate the total problem.

Against these negative notes, what did the employment planning committee accomplish the first year?

First of all, we dramatically learned the areas in which we have to seek more answers—and by "we" I mean laymen and professional workers alike. It is an important factor in the functioning of the employment planning committee that we learned this fact in the tradition of democracy—a cross-section and interdisciplinary exchange of ideas and information that brought new awareness to all involved.

The fact must be accepted that the employment planning committee (even thousands of employment planning committees across the country) is not going to answer the problem alone—but it is *one* approach and an important approach. When such a committee is established, it seems essential

that its members understand as early as possible the tremendous expanse of the problem, and reach an understanding of their niche in fighting it. The facts and problems have to be discussed, and the limitations of the approach, or the committee members can become overwhelmed by the size of the challenge and never be able to see the real contributions they can make.

Employers and professional workers alike agreed that the essence of the employment planning committee is that it is a "foot in the door." It is not just a foot into an individual employer's office; because the committee has really involved, very deeply, a group of persons representative of the community, we have an ever-widening group eager and anxious to help find the solutions. Further, this is a group that will be willing not only to help find the solution to the "employment" problem *per se*—but to the whole range of problems which community leadership must deal with relative to mental illness. As a beginning recognition of this, our committee, which for the first year used the presentation of a patient as its main educational media, is now well on its way toward searching for other effective educational means which might involve even broader community participation. Again, this step seems indicative of the maturation process achieved among committee members during the first year of the program.

In addition, the committee has unquestionably proved a vital bridge between the professional workers and the laymen of the committee and community.

If we can keep in focus that such a committee accomplishes a tremendous amount if it does nothing more than provide another type of bridge between the patient, the professional worker and the community, we can see a tremendous value in and a widespread continuing need for similar committees in all cities of the country.

ELLIOTT McGINNIES, PH.D.

The role of mental health films in community discussion groups

The idea that motion pictures may be effective modifiers of opinions, attitudes and beliefs is rather widely held and has a respectable history. Peterson and Thurstone [1] were among the first to show a relationship between exposure to films and attitude change, although their conclusions have not been accepted without considerable reservation by other investigators in this area.[2] In general, the persuasive power of the motion picture seems to depend upon a number of factors, including the type of film, the number of films employed, and the age and background of members of the target audience. Nevertheless, the efficiency and economy with which films may be employed in reaching mass audiences have resulted in their widespread use for purposes of education and indoctrination. The almost universal appeal of the "movies" lends further attractiveness to this method of mass persuasion.

In the field of mental health education there is an acute need for communication techniques that will not only be effective in imparting information or modifying attitudes but will also have sufficient appeal to attract audiences. The sound film seems to meet these requirements, and consequently a large number of films dealing with various types of problems in the general area of mental health have been produced and distributed. These are generally shown to interested groups composed of students, parents and educators. A frequent procedure is to follow presentation of the film with group discussion of the film and related topics. Such discussions may be led by a qualified professional person or, in some instances, by a layman who holds a position of leadership in the group.

Despite optimism in professional circles concerning the probable effectiveness of

Dr. McGinnies is associate professor of psychology at the University of Maryland.

[1] R. C. Peterson and L. L. Thurstone, *Motion Pictures and the Social Attitudes of Children*, New York, Macmillan, 1933.

[2] F. Fearing, "A Word of Caution for the Intelligent Consumer of Motion Pictures, *Quarterly of Film, Radio, Television*, 6(2, 1951), 129–42.

these procedures in effecting more desirable attitudes toward mental health among typical audiences, little research has been done until recently to evaluate this assumption. Under the impetus provided by the special grants section of the National Institute of Mental Health, the author and his coworkers are nearing completion of a 4-year program of study into the role of mental health films in community discussion groups. As a corollary to this main task we have also evaluated the effects of films in groups that were not afforded an opportunity for discussion of the films. Extension of the research into the effects of films upon opinions and beliefs about mental illness has clarified some of the problems in this area. Systematic manipulation of the structure of some of our groups has yielded information concerning the interaction between the attitudes of audience members and their reactions to such dynamic films as "The High Wall," which attacks in forthright fashion the problems of group prejudice.

It is the purpose of this paper to outline some of the problems faced by the investigator in this area and to summarize some of the more salient results of our current research program. It is hoped that this information will be useful to the many individuals engaged in communications research who contemplate study of some of the aspects of persuasive communication that are described here.

SOME METHODOLOGICAL CONSIDERATIONS

Sampling problems. In the process of contacting groups to participate in the proposed research, it soon became apparent that our observations would necessarily be limited to certain economically and educationally favored segments of the population. PTA, child study and student groups were available for study in the suburban areas of Washington, D. C., but only the high school students could be said to approximate a cross-section of the general public. The very fact of participation in adult groups formed for the purpose of self-education or public service in the mental health area reflects the selective operation of such factors as education, income and community leadership. Those persons, on the other hand, who probably have the most need for enlightenment about mental health are the least likely to spontaneously join groups engaged in this type of activity. Techniques for engaging the cooperation of such unaffiliated individuals in research programs of this type have yet to be developed.

On the average, our group members could be described as women in the age range from 30 to 50, having one to four children, and enjoying an annual family income of around $6,000. A few of the groups contained some men. The educational level of the participants ranged generally from completion of grade school to some college training. Although the groups that we have studied cannot be claimed as representative of the population at large, they are probably fairly typical of the types of groups that undertake educational programs in the field of mental health. Results obtained from such groups, therefore, can be assumed to represent the reactions to mental health films of similar individuals throughout the country who have viewed and discussed these films.

Data collecting. In evaluating the role of mental health films in community groups, one is concerned with two principal features of this situation. The first involves group reaction to the film as expressed in organized discussion, and the second is in-

dividual reaction to the film as determined by the use of questionnaires. Each type of data has a certain unique value. Since discussions of these films are generally held as a means of stimulating mutual interest in mental health problems, analysis of the discussion process is essential in evaluating its actual usefulness for this purpose. Since not all members of the groups will participate in discussion, however, the reactions of some individuals to the film cannot be determined by observation of verbal behavior. The effects of a film upon all of the audience members, whether or not they participate in discussion, can be assessed to some extent by the use of questionnaires and inventories. These can be administered both at the conclusion of the film and at the termination of the discussion to determine in what way, if any, the discussion has implemented the impact of the film.

As Bales [3] has demonstrated, a group discussion may be analyzed both for its "process content" and its "topical content." By "process content" is meant the dynamic or motivational features of group interaction revealed in the types of comments that are made. Analysis of this type evaluates such features of the discussion as solidarity, tension, tension release, etc. "Topical content," on the other hand, refers to *what* is said in the discussion, that is, to the substantive rather than the interpersonal nature of the comments that are made. Although both approaches are useful, the former tells us more about the group and the latter reveals more about the nature of the communication being discussed.

Since we were interested in both of these descriptive categories, we arranged to tape-record the discussions to preserve all of the verbal material for analysis by several different techniques. While certain nonverbal communicative acts are lost through this method, it was felt that subjective judgments concerning these would be of limited value in systematic description of the discussion situation. To preserve the naturalness of the group setting all dicussions were held in the usual meeting places of the participating groups. The recording equipment was in place when the participants arrived and was arranged so as to be relatively unobtrusive. No effort was made to conceal the fact that the discussions would be recorded. All groups were informed of this procedure and the members were assured of anonymity. A method was devised, however, for recording the order of individual participations, so that we knew, for example, how many times a given person (identified by a symbol) entered the discussion and how much he said. This procedure made it possible to develop frequency distributions of verbal output in various types of groups and to match any individual's discussion comments with biographical information previously obtained from him on a questionnaire. Some of the findings from our study of these relationships will be mentioned later. For a more detailed description of this methodology the reader is referred to an account published elsewhere.[4]

Selection of films. The National Institute of Mental Health has published a selective guide of mental health motion pictures listing well over 100 such films. To obtain sufficient data about any particular film to support tenable generalizations, we included only nine different films in the research. These were selected on the basis of their

[3] R. F. Bales, *Interaction Process Analysis,* Cambridge, Addison-Wesley, 1950.

[4] E. McGinnies, "A Method for Matching Anonymous Questionnaire Data with Group Discussion Material," *Journal of Abnormal and Social Psychology,* 52(1956), 139–40.

relatively high usage as well as the fact that they represented two general topics of wide interest, namely, child and family relations and mental health problems. The films dealing with the child and family were "Your Children and You," "Angry Boy," "Meeting Emotional Needs in Childhood," "Farewell to Childhood" and "Why Won't Tommy Eat?" The films concerned with mental health problems were "Breakdown," "The Feeling of Rejection," "The Feeling of Hostility," and "The High Wall." Approximately 70 groups will have viewed one or more of these films at the conclusion of projects currently under way.

Since the effects of these films upon opinions and beliefs about mental health may be a function of whether they are shown singly or as a series, this factor was investigated. Both large and small discussion groups were observed to determine whether audience size is a factor influencing individual responses to the films. Techniques were developed for describing the kinds of discussion resulting from different films, and the specific reactions of discussion group members to the films were summarized through content analysis of the discussion protocols.

Discussion leadership. One of the critical variables in the discussion situation is the role assumed by the discussion leader. In general, the leader can take one of two positions: he can be "directive" or he can be "permissive." The directive leader sets the tone of the discussion by interpreting the film for the audience before inviting their reactions. He responds directly to questions and makes his own opinions clear on controversial issues that develop. A permissive discussion leader, on the other hand, avoids interpretation of the film to maximize the expression of conflicting interpretations by the group members. He "reflects" questions back to the group for consideration rather than answering them himself, and he avoids dogmatic expression of his own opinions about problems that arise.

In the results to be reported here, we have made consistent use of the permissive or non-directive type of discussion leadership. Our purpose was not to proselytize members of the participating groups with any particular set of mental health maxims, other than those subscribed to by the film producers. We were interested in the reactions of audience members to the films and to the discussion situation rather than in their response to a positive type of discussion leadership.

Non-directive leadership can be achieved with relatively little difficulty and can be employed with a minimum of variation in different group settings. It thus has the dual advantages of being susceptible to systematic control and of evoking a high degree of spontaneous participation from members of the discussion group. The effects of different types of leadership upon the discussion process are currently being examined, using a single film with groups having similar educational and economic backgrounds.

EXPERIMENTAL FINDINGS

Quantitative Measures of Discussion Behavior

Distribution of verbal output. Of some importance, both theoretically and practically, is the distribution of participation among the members of different types of discussion groups. While most human characteristics follow the so-called "normal" curve of distribution, this is not the case with behavior that is subject to certain external limitations or constraints. It has been shown, for example, that where pres-

sures toward social conformity exist, behavior tends to be distributed in the form of an inverted-J, with most individuals falling at one extreme of the curve. This type of distribution is also found in most discussion group situations, although the constraints that operate are probably different from those underlying other J-functions.

From verbatim transcripts of discussions in both large and small groups we have tallied the total verbal output as well as the number of discrete participations for all individuals. In nearly all of these groups participation falls short of 100%. As total verbal output increases to 1,000 words during a half-hour period, the percentage of contributors falls off sharply as the higher frequencies are approached. Most of the discussants fall into the 100- to 600-word range. A high positive correlation exists between the number of times an individual speaks during a discussion and the total number of words he uses, so that for practical purposes the number of participations rather than the number of words used may be taken as a measure of discussion activity.

Having determined that verbal productivity in most groups is best described by a J-shaped function, we became interested in possible determinants of this distribution. A biographical inventory designed for use in the project provided a number of predictor variables that could be validated against the actual verbal behavior of the discussion group members. Dividing these individuals into participants and non-participants, according to whether they had voluntarily contributed to group discussion, we determined which of the biographical factors on the questionnaire differentiated between the two groups. It was found that two factors—education and leadership—were the most general and reliable predictors of participation or non-participation in group discussion. Reported in detail elsewhere,[5] this analysis suggests that the individuals most likely to participate in discussion enjoy a superior education and hold positions of leadership in various community groups.

Spontaneity and recruitment. Two additional measures of discussion behavior were developed as indices of certain temporal features of the discussion process. The extent to which a discussion proceeded without dependence upon the discussion leader was defined as "spontaneity." Quantification of this discussion attribute was accomplished by taking the ratio of spontaneous to total comments during a given interval of time. Spontaneous comments were those which followed remarks by other members of the group, and non-spontaneous comments were those elicited by prompting from the discussion leader. In general, we have found that spontaneity is rather low at the beginning of a discussion and that it increases in linear fashion throughout the discussion period. While this trend is similar in both large and small groups, over-all spontaneity is considerably greater in small groups. We also have evidence that groups composed of individuals with either positive or negative attitudes toward the film under discussion display greater discussion spontaneity than neutral or disinterested groups.[6]

In many discussion situations, it is considered desirable to enlist the participation of as many group members as possible. It would be interesting, therefore, to know something about the rate at which previ-

[5] E. McGinnies and W. Vaughan, "Some Biographical Determiners of Participation in Group Discussion," *Journal of Applied Psychology*, 41(1957), 179–85.

[6] E. McGinnies and I. Altman, "A Statistical Approach to Group Discussion Analysis," Technical Report No. 8 submitted to the National Institute of Mental Health in May 1957.

ously inactive persons enter the discussion. Since our observational techniques enabled us to plot the exact time at which any individual group member spoke, we were able to determine the cumulative rate at which new participants were "recruited" into the discussion. For most groups recruitment proceeds as a negatively accelerated growth function, that is, new participants are added rapidly during the early stages of the discussion and at a progressively slower rate as the meeting continues. In fact, discussion leaders may anticipate that halfway through the discussion practically all of the active participants will have been recruited; very few, if any, new discussants will be added after this time.

Rate of recruitment also varies with the size and type of group. The rate is faster in small than in large groups, and the function is steeper with groups that have well-defined attitudes toward the film than in groups that are neutral toward the film content. It should be noted that the results described here were obtained with non-directive discussion leadership. It is conceivable that different types of leadership would affect all of the measures employed, and that participation, spontaneity and recruitment might all be systematically altered by employing, for example, a directive leader. Conversely, these measures might be used as independent indicators of the type of approach used by the discussion leader. Perhaps certain dimensions of discussion leadership could best be described in terms of these quantitative indices of group behavior. This, of course, remains a problem for future research.

[7] The method and results of this analysis are described fully by Clagett Smith in Technical Report No. 5 (Part A) and by Dr. Irwin Altman in Technical Report No. 5 (Part B), submitted to the National Institute of Mental Health in June 1955 and July 1956.

Qualitative Measures of Discussion Behavior

Discussion content. While the measures just described have proved useful in detecting certain quantifiable differences among discussion groups subjected to varying experimental conditions, they admittedly fail to probe one of the most important features of the discussion, namely, the topical content. Any evaluation of the effectiveness of a film as a stimulus for group discussion must include examination of certain substantive aspects of the discussion material apart from its statistical properties. The task of content analysis with data of this sort involves certain methodological hazards. Discrimination between topical categories in the verbal material studied requires construction of a reliable system for coding the selected verbal units. The more categories contained in such a system the greater is the probability of error, with a consequent reduction in the reliability of the coding. A small number of categories, on the other hand, promotes reliability but does so at the expense of sensitivity.

As an initial attack upon the data we decided to adopt a limited number of content categories. From experience with a number of groups and from careful examination of the discussion protocols it was apparent that individual comments were oriented about several main areas of interest. Discussants seemed to direct their remarks ward (a) the film, (b) mental health problems and concepts in general, and (c) personal experiences with mental health problems and concepts. A certain number of comments fell in none of these categories and were assigned to a (d) residual or miscellaneous classification.[7]

As a coding unit we selected any utterance having a subject and a predicate, either explicit or implied. Use of this

grammatical unit greatly simplified both the problem of defining the unit of analysis and of training observers to classify the units according to the categories adopted. Intercoder reliability using this system has consistently risen above .90. In addition, most of the discussion comments fell readily into one of the three categories, with very few being designated as miscellaneous.

Results of this analysis have proved highly provocative with respect to the stimulus value of different films in the group discussion setting. Certain films, such as "Angry Boy," provoke a majority of comments in the *film* category. The film, "Meeting Emotional Needs in Childhood," on the other hand, stimulates a large number of comments about *mental health* and *personal experiences* and relatively few about the film. Discussion of *personal experiences* tends to follow the film "Why Won't Tommy Eat?" Furthermore, these trends are consistent with different groups discussing the same film. It is clearly evident that these films play different roles in the discussion situation when their impact is analyzed according to the general content of the ensuing discussion. This knowledge is potentially useful to discussion leaders, who can prepare to more effectively moderate the discussion according to the topics of concern most likely to arise. Film producers who intend a particular effect from a production might examine their material in light of the known effects of similar films already in use.

Although we are not prepared to justify these assumptions in detail, we may venture a few hypotheses concerning the types of films that are associated with certain consistent patterns of discussion content. Discussions appear to center around the film itself whenever a central theme is exploited and where several main characters dominate the action. In films where mental health concepts are presented through a series of unrelated episodes, or vignettes, audience attention is drawn away from the film itself and onto the general problems and principles that have been illustrated. The absence of a well-defined plot and detailed characterizations of the players seems to reduce focusing of discussion upon these aspects of the film. Finally, films which portray fairly common problems, such as those encountered in parent-child relationships, encourage audience members to discuss their own experiences in these areas. This seems to be particularly true when the incidents are non-threatening in nature. Greater reluctance to discuss personal problems is generated when the film deals with aspects of mental illness, although comments about general problems in this area are stimulated.

Detailed content analysis of discussions. The method just described yields results that permit us to classify mental health films according to their main effects upon discussion content. From the point of view of those planning, producing and using such films, however, a more detailed analysis is needed. This task requires a method that is admittedly less objective and precise than that previously employed. It is one thing to code a remark as applying to mental health and quite another to determine exactly what is being said with reference to this general area. Nevertheless, a breakdown of the recorded protocols was undertaken for the purpose of describing more completely the reactions of audience members to the several films used in the project.

Preliminary work with the discussion material led us to formulate four additional categories of reaction to the film content. These were (a) adverse criticisms of the film, (b) commendatory remarks about the film, (c) questions about mental health

stimulated by the film, and (d) general topics of discussion raised by the film. An analyst reviewed the discussion protocols and recorded comments relevant to these four categories. Since each of the films had been discussed by at least two groups, the summaries of comments for the different groups that had viewed the same film were compared for basic similarities. A composite picture of the reactions of several groups to a single film was thus generated in terms of the four response categories. This procedure tended to eliminate reactions peculiar to a particular group and provided a sort of "average" description of group reactions to particular films.

Obviously, this is not the place for a detailed review of the findings resulting from this analysis.[8] However, the general method is suggested as useful for determining in fairly systematic fashion something about the response of community groups to films of this nature. While anecdotal reports of group reactions to mental health films are frequently obtained, their value is mitigated by the variations in observer reliability that must be expected under such uncontrolled conditions. As an example of the type of summary information that may be obtained by systematic inspection of exact protocols, the report on discussant reactions to the film "Breakdown" is presented.

BREAKDOWN (sound, 41 minutes)

Produced by the National Film Board of Canada and released by McGraw-Hill in 1951.

The film was adversely criticized on these points:
1. It did not indicate the causes of the girl's illness.
2. It presented an unrealistically modern and progressive mental hospital.

Commendable aspects of the film:
1. It was forceful and impressive.
2. It presented the various types of hospital treatment in an understandable manner.

These questions appeared consistently in the discussion:
1. How could this girl's illness develop so far without being noticed?
2. What should a person do when someone he knows suddenly starts going insane?
3. What is the difference between "mental breakdown" and "nervous breakdown"?
4. How do you know when certain symptoms forecast serious mental illness?

Group leaders may expect discussion of these areas:
1. The origins and symptoms of schizophrenia.
2. Public reactions to mental illness.
3. The functions of the social worker.
4. Factors which hamper the effectiveness of mental health facilities.

None of the films was free from criticism; neither did the groups fail to find commendable aspects of each production. One observation of possible interest to film distributors is that obsolete settings and costumes were immediately commented upon in most of the discussions. College students are particularly cognizant of any deviations from contemporary styles, and the effects of outmoded settings upon these groups include much hilarity and scoffing. The message of the film can be substantially mitigated by such distractions as this. Contemporary audiences are accustomed to the lavishly produced films of Hollywood, as well as to professionally detailed television offerings, and they expect the same technical quality in educational films. For this

[8] Technical Report No. 6, prepared by Richard Page and submitted to the National Institute of Mental Health in June 1956.

reason, it might be advisable to withdraw mental health films from circulation when they become obviously dated and to replace them with current and improved versions.

Several informal observations of group reactions to the films are worth mentioning, even though these are implied in the content analyses. For one thing, relatively sophisticated audiences, such as those found in child study groups from upper middle-class neighborhoods, engage in considerable "psychologizing" in response to the films. Many individuals in such groups are familiar with such concepts as repression, displacement, adjustment, emotional maturity, psychosomatics, etc., and they tend to use these terms freely, albeit somewhat inaccurately, in discussion. It thus becomes imperative in most instances that the discussion leader have at least a working knowledge of these concepts. Another tendency of our discussants was to request information beyond that presented in the films regarding the dynamics underlying the various behavior problems that were illustrated. In "Breakdown," for example, a major portion of the discussion focuses on the origins and symptoms of schizophrenia. Our group members agreed almost unanimously that the film was greatly at fault for not presenting the causes of the principal character's mental illness, and they devoted much time to speculation about possible reasons for the episode. Without a clear mandate from the film, audience members tend to believe that inherited weaknesses of some kind predispose individuals to such illness.

A similar type of discussion tends to ensue from the film "Angry Boy." The participants examine in detail the personality dynamics of all of the family members portrayed in the film, expressing not only their own theories but any psychological insights to which they have been exposed. It should not be assumed that the bulk of such speculation is erroneous; on the contrary, the members of upper-level groups display considerable facility in discussing elementary principles of human relations. They do not minimize the seriousness of the problems presented nor do they offer simple and easy solutions. For this reason, perhaps, they expect the films to provide more diagnostic explanation and to prescribe courses of actions that will avoid difficulties similar to those dramatized.

OPINION CHANGE RESULTING FROM VIEWING AND DISCUSSION OF FILMS

Although our initial concern in this research focused upon the discussion situation, we were not unaware that the ultimate goal of film-discussion programs is to bring about not only an increasing awareness of the importance of mental health problems but also greater knowledge of certain basic psychological principles relevant to this area. Consequently, we devoted some time to the construction of an instrument for measuring opinions about mental health problems and concepts and to the use of this inventory with groups that had viewed varying numbers of films under discussion and non-discussion conditions.

Through pre-testing and item-analysis of a number of statements relating to mental illness, Smith [9] selected 47 items with which respondents could indicate agreement or disagreement along a 5-point scale. This mental health opinion inventory was given to 12 staff psychologists at the University of Maryland to establish the direction of

[9] C. G. Smith, "Communicating Mental Health Information in Community Discussion Groups," unpublished M.A. dissertation, University of Maryland, 1956.

professional judgment on each item. Subsequent scoring of the questionnaire was then done in accordance with the expressed opinions of these "experts." Following are examples of the types of items used:

It is better not to discuss a mental illness as one would a physical illness.

Few of the people who seek psychiatric help need the treatment.

An employer should avoid hiring someone who has been in a mental hospital.

Nervous breakdowns are due to overwork.

Two experimental procedures were designed to test the effectiveness of mental health films, employed singly or in a series, in influencing the responses of viewers to the items on the inventory. In the first study a series of three films was shown to adult community groups composed largely of women of middle and upper-middle class standing. Two such groups, of approximately 15 members each, viewed and discussed the films "The Feeling of Rejection," "The Feeling of Hostility" and "Breakdown" at bi-weekly intervals. Two comparable groups saw the same three films under similar conditions, except that no discussions were held.

The results of this study, which are reported in detail elsewhere,[10] showed that significant shifts of opinion in the direction of greater sophistication about problems of mental illness occurred in both sets of groups. The hypothesis that greater opinion change would occur under discussion than under non-discussion conditions was not confirmed. Two control groups, which simply responded to the questionnaire before and after a 6-week interval, showed no change in their mean scores. It was concluded, therefore, that a series of three films dealing with mental illness are effective in modifying opinions in this area and that discussion of the films does not enhance the measurable effects.

It was possible, of course, that a single film might have had an equally salutary effect upon opinions about mental illness. It was also conceivable that one of the three films in the series was responsible for most of the influence effect. A second experiment was designed to test these possibilities. Six more community groups were formed, comparable in all important respects to those previously observed. Three of these groups each viewed and discussed one of the three films used in the prior study. The remaining three groups saw the same films without discussion. The mental health opinion inventory was administered approximately four weeks prior to the experimental sessions and again immediately afterward.

Analysis of the questionnaire data showed no difference in opinion change under discussion as compared with non-discussion conditions. Only one of the six groups moved significantly in the predicted direction, and this was composed of individuals who had seen but had not discussed "Breakdown." The overall effects, however, lead to the conclusion that a single mental health film, with or without discussion, does not necessarily bring about a substantial modification in the opinions of audience members about related matters.

So far as film users are concerned, the results of these two investigations indicate that learning may be accomplished with a series of films where a single film generates no measurable effect. Film producers may note that the failure of group discussion

[10] E. McGinnies, R. Lana and C. G. Smith, "The Effects of Sound Films on Opinions about Mental Illness in Community Discussion Groups," *Journal of Applied Psychology*, in press.

to augment the influence process argues for the ability of the films to stand by themselves, so to speak. It should be emphasized, however, that group discussion can be justified on grounds other than that of promoting opinion change. There was noticeable discontent among the members of the non-discussion groups in both studies; they were eager to exchange reactions to the films after having viewed them. In addition, evidence from another phase of the project indicates that while the immediate persuasive effects of a film may be no greater in discussion than in non-discussion groups, delayed measurement shows less attenuation of opinion change among the members of groups that have discussed the film.

ATTITUDE AS A FACTOR IN THE INFLUENCE PROCESS

The average person probably does not go out of his way to be exposed to persuasive communications that run counter to his particular beliefs and prejudices, although certain situations may force him into such contacts. Audiences who elect to attend films and lectures may be presumed to consist of individuals who are in general agreement on the issues to be presented. In other situations, of course, where controversial matters are presented for group consideration, differences of opinion frequently lead to lively debate. The difference between these two types of settings might be illustrated by a political rally, which only like-minded partisans are likely to attend, and a school board meeting, where inflammatory issues such as integration may arise.

It seemed likely, therefore, that prediction of the effects of a persuasive film upon audience members would rest in part upon knowledge of the attitudinal dispositions of the recipients. *A priori* reasoning led us to suspect that the reactions of group members who are in disagreement with a film message would differ measurably from those of individuals who share the viewpoint taken by the film. Several variations in group structure, with respect to existing attitudes, are possible. The group may be composed of persons who are relatively homogeneous in their attitudes and opinions; or the group may consist of persons with differing attitudes, with the balance of opinion either being evenly divided or so distributed as to favor one faction or the other. Our investigations have led us to examine both of these general possibilities, and some interesting findings have emerged with reference both to the discussion process and to attitude change under the influence of a mental health film.

Control of group structure is difficult to achieve when studying community groups. Since the group members have volunteered for participation in the discussion sessions, the imposition of restrictive experimental conditions is seldom well received. To work in a setting where adequate controls could be exerted over the major variables of the experiment, Mitnick [11] secured the cooperation of two high schools. Twelve experimental groups, each composed of nine high school students, viewed "The High Wall," after which six of the groups held discussions of the film, while the remaining six returned to their classes without discussion. An additional six groups served as controls and were simply given questionnaires at predetermined intervals. All of the groups were formed on the basis of scores obtained by the members on a slightly modified form of the California ethnocentrism scale, which had been ad-

[11] L. L. Mitnick, "Influencing Ethnocentrism in Small Discussion Groups through a Film Communication," unpublished Ph.D. dissertation, University of Maryland, 1956.

ministered to over 400 students. On the resulting distribution of scores (which was nearly symmetrical), cut-off points were established to designate individuals who were high, medium or low with respect to ethnocentric disposition. Within each category of ethnocentrism, nine individuals were assigned randomly to each of three conditions: film-discussion, film-alone and control. This was done for each of the participating schools, so that a total of 18 groups, including control, took part in the experiment.

Members of the film-discussion groups representing high, medium and low degrees of ethnocentrism were given 30 minutes in which to discuss the film and related issues. The group members were free to participate in the discussion or not, and the discussion leader assumed a permissive, or non-directive, role. At the conclusion of the discussion, the subjects again answered the E-scale. The members of the film-only groups viewed the film under comparable conditions but did not engage in discussion of it. The control groups responded to the E-scale at the same times as the experimental groups but without any intervening exposure to either the film or a discussion.

All members of the experimental groups were tested both for amount of factual material learned from the film and for evidence of attitude change, as shown by post-treatment scores on the E-scale. One month following the experimental treatments, all of the groups were readministered the E-scale, and the groups that had viewed the film under either discussion or non-discussion conditions were also given the information test.

The major findings of this study may be summarized as follows:

1. Members of both the film-discussion and film-alone groups showed significant reductions in ethnocentrism after viewing the film. For the tolerant subjects this effect was greater in the discussion than in the non-discussion groups. Attitude change among the prejudiced individuals, however, was less in the discussion groups than in the film-alone groups. Opportunity for discussion apparently detracted from the effects of the film by allowing these persons to reaffirm the ethnocentric convictions that they held originally.

2. The stability of attitude change was also related to the experimental conditions. Members of the discussion groups, when tested one month later, had largely retained their post-treatment gains, while members of the film-alone groups had regressed significantly toward their original position. Even the passive, or non-participating, members of the discussion groups showed greater persistence of attitude change than members of the film-only groups.

3. The amount of information learned from the film was related to initial attitude. Those individuals who were initially low in ethnocentrism learned more from the film than those high in ethnocentrism. In addition, it was found that the subjects who voluntarily participated in discussion had learned more about the film than those who did not participate.

4. The amount of factual information learned from the film after a 1-month interval was related to initial attitude. The tolerant subjects achieved the highest retention-of-information scores; the prejudiced subjects obtained the lowest scores.

From analysis of tape-recordings of the discussions, it was apparent that the discussion process reflected rather dramatically the attitudinal composition of the groups. The extreme individuals, those either high or low on the E-scale, generated the most

active discussions measured in terms of sheer verbal output. The low E (tolerant) students held the liveliest discussions, the high E (prejudiced) students were next, and the middle E (neutral) students were least active in this respect. Measures of spontaneity and recruitment showed similar trends, with a positive attitude (either tolerant or prejudiced) leading to greater spontaneity of discussion and more rapid enlistment of participants into discussion.

It is apparent from this investigation that the existing attitudes among members of homogeneous groups are factors determining the amount learned from a film, but that attitude change may be generated irrespective of such predisposition. Group discussion is more effective for persons favorably disposed toward the film content and also results in greater stability of attitude change. The discussion process itself reflects the attitudinal structure of the groups. We are currently engaged in a project designed to measure the effects upon both attitude and discussion behavior of "The High Wall" when shown to groups composed heterogeneously of persons with varying degrees of ethnocentric bias.

SUMMARY AND CONCLUSIONS

There is little doubt that mental health information is of vital concern to millions of persons; the statistics on the incidence of first admissions to mental hospitals attest to this fact. Dissemination of knowledge about mental health principles, however, cannot be undertaken with complete confidence until we have reached a more satisfactory definition of "mental health." Investigation into the more commonly accepted beliefs of individuals in this area is currently under way in several research centers. It may be expected that with continuation of such inquiry into the convictions of the average person about child-rearing practices, child and family relations, mental illness and related topics we will be able to approach the matter of rectifying popular misconceptions in more systematic fashion. Until more information along these lines is available we can only employ the most effective means at our disposal for communicating current professional opinion on mental health problems and concepts. Certainly one of the most useful and economical vehicles for this purpose is the sound motion picture.

Although modest in scope and execution, the research efforts reported here indicate that evaluation of the role of mental health films in community discussion groups is both feasible and instructive. The discussion process itself is susceptible to rather precise description through a variety of techniques. Analysis of the pattern of individual participation in group discussion reveals significant differences in the biographical characteristics of active as opposed to passive members. Certain basic questions concerning the contribution of a group discussion to opinion change under the impact of one or more films have been raised through observation of groups under discussion and non-discussion conditions. Finally, the interactive effects of discussion and initial attitude have been studied in groups of known attitudinal structure. The results of these research efforts have increased our understanding of this particular type of persuasive situation and have suggested a number of avenues for further investigation.

Involving, as it has, both theoretical and applied aspects, the research conducted under this special grant has afforded the investigators an opportunity to examine certain aspects of group behavior under naturalistic settings and to test hypotheses that transcend the usual laboratory situation.

As usual in exploratory research of this nature, we have raised more questions than we have answered. The summary presented here, however, may be of value both to those committed to educational efforts in mental health and to those contemplating research in this important field.

ACKNOWLEDGMENTS

A project of this type requires the cooperation of a number of persons. It is a pleasure to acknowledge the assistance of Dr. Richard Bell and Dr. Hyman Goldstein in planning the research. Dr. Joseph Bobbitt provided continuing advice and support throughout the study. The research assistants whose labors have generated the results reported in this paper were Irwin Altman, Willard Vaughan, Clagett Smith, Leonard Mitnick, Robert Lana and Richard Page. Mrs. Mildred Nale handled all of the frequently difficult secretarial tasks. The project was supported in part by the special grants section of the National Institute of Mental Health, U. S. Public Health Service, Department of Health, Education and Welfare.

Book Reviews

PSYCHIATRIC NURSING

By Ruth V. Matheney
and Mary Topalis

St. Louis, C. V. Mosby Co., 2nd ed., 1957, 259 pp.

According to the preface to the first edition, "This book is written for the present and is intended for students in basic schools of nursing during the transition period that psychiatric nursing is undergoing."

The student nurse is presumably having clinical experience in psychiatric nursing in the special unit of a general hospital or in a mental hospital as an affiliating student.

The preface to the second edition retains the scope, purpose and organization of the first, with some additions which present explanations of therapies being developed in the treatment of mental patients.

The subject matter is divided into units that develop logically from Chapter 1, which describes the nurse's role in the mental health program, through nursing care of patients with various types of behavior disturbances.

Unit 1 presents the evolution of personality, the psychoanalytic theory of personality development and deviate patterns of behavior. The importance of the nurse in therapy, her personality and ability to understand and accept her own capabilities and limitations, is well established.

Unit 2 establishes the principles of psychiatric nursing. Acceptance of the patient with his problems and an understanding of his need is the basic theme developed.

Units 3 and 4 consider functional deviations and behavior disorders due to organic factors, along with the nursing care involved. Therapies involving major nursing responsibility, as they are being employed with mental patients, include insulin and electroshock treatment, psychosurgery, narcoanalysis, prolonged narcosis, hydrotherapy and the tranquilizing drugs.

The value of this presentation is not limited to student nurses. All members of the therapeutic group might find the information interesting.

Unit 5 has special value for all nurses and others meeting problem personalities. Alcoholism is a major social economic and health problem. Dependence upon alcohol as a problem solver, a protection from emotional trauma or a method of forgetting unpleasant reality is "considered a symptom or a disease and may be either." Nursing care and rehabilitation methods are presented.

Nursing care of patients who depend on drugs is a subject that has important implications for the nurse in her professional work and as an individual. Drugs also provide escape or support in times of stress for the emotionally unstable. The various drugs involved and methods employed to liberate the addict are considered, along with the appropriate nursing care and support through adjustment.

References follow each chapter. The items suggested are timely and inclusive.—MARY E. CORCORAN, Brooklyn, N. Y.

EDUCATION AND MENTAL HEALTH

By W. D. Wall

New York, Columbia University Press, 1956, 347 pp.

This book is a unique publication in that it is the result of a conference of experts in the field of mental health but is by no

means just a symposium of their views. In 1952 sixteen representatives of member states of UNESCO spent several weeks in Paris studying an extensive series of documents previously prepared concerning mental health of children. In addition to these conference participants, several experts from UNESCO and many short-term consultants were employed in the project so that it can be said that over 100 persons were involved. The book itself was prepared by W. D. Wall and one gets the impression that excellent work has been done in putting together the results of the conference and presenting an integrated discussion of a very important subject. Furthermore, the book is written in rather simple non-technical language so that it can be used by parents and by teachers as well as by experts in the field.

The central idea behind the organization of the conference was that "the balanced development of the individual, intellectually, emotionally and socially, is now constantly threatened by the disturbance of community values owing to the two wars of which Europe has been the theatre." It should be said also that it represents the growing recognition that the task of schools can no longer be confined to the training of the mind. The school must share with other agencies of society not only in transmitting the cultural heritage but in inculcating values, ideals and modes of behavior.

The coverage of the book is ambitious in nature in that it discusses mental health from the standpoint of the family, school and community. In the material concerning the school the entire area from preschool through the adolescent period is included.

Certain definite points of view are presented, but one gets the impression that the conference recognized the fact that complete answers are not available for many of the problems of mental health. Remedies are suggested, but in a modest way so that the reader will realize that answers differ according to conditions. Many of the ideas are not revolutionary; they have been known for some time. On the other hand, it would certainly cause a revolution in society if these ideas could actually be put into practice.

The book recognizes the mutual dependency of factors in society. For example, in the chapter entitled "Some Unsolved Problems" it is recognized that individuals are dependent upon many of the values and modes of control organized by society. At the same time the book places proper weight upon the contribution which the individual must make toward the development of societal values of good will and international understanding.

In connection with the work for the training of teachers, considerable emphasis is put upon practical relationship between teachers and pupils in this training in opposition to a course of education based upon theory and study of textbooks. It is interesting that support is given to the idea that teachers may be made effective in the field of mental hygiene without the amount of "general education" which is at present advocated in the United States. In a period of teacher shortage it may well be that research will be needed in discovering the most valuable courses which a teacher, who cannot take the prescribed amount of education before entering the classroom, should have.

The bibliographies following each chapter are extensive and wide in coverage. Naturally, they will be of less value to teachers in the United States than to teachers in Europe because many of the authors are Europeans and language difficulties will result.—DR. R. L. WEST, Trenton State Teachers College.

CHALLENGING GIFTED CHILDREN

By Jack W. Birch

and Earl M. McWilliams

Bloomington, Ill., Public School Publishing Company, 1955, 49 pp.

SOLVING PROBLEMS OF PROBLEM CHILDREN

By Jack W. Birch

and Edward H. Stullken

Bloomington, Ill., Public School Publishing Company, 1956, 44 pp.

RETRIEVING THE RETARDED READER

By Jack W. Birch

Bloomington, Ill., Public School Publishing Company, 1955, 32 pp.

REACHING THE MENTALLY RETARDED

By Jack W. Birch

and Godfrey D. Stevens

Bloomington, Ill., Public School Publishing Company, 1955, 44 pp.

HANDWRITING FOR LEFT-HANDED CHILDREN

By Luella Cole

Bloomington, Ill., Public School Publishing Company, 1955, 17 pp.

These five booklets, which vary from 17 to 49 pages in length, are included in a series designed to give practical suggestions for "teaching exceptional children in every classroom." Jack W. Birch, director of special education in the Pittsburgh schools, is the sole or major author of four of them.

The psychological principles on which these four books are based are, as they should be, essentially the same. They reflect a conventional, somewhat conservative and practical orientation. The following list of paragraph headings, quoted from the booklet called *Solving Problems of Problem Children* gives the essence of the authors' psychology: Behavior is Symptomatic, Behavior is Purposive, Cases Must Be Treated on an Individual Basis, Consistency and Continuality are Necessary, Attitudes are Important, The Total Situation Must Be Known, Example is More Important Than Precept, Normal and Abnormal Behavior Must Be Differentiated, Friends Are Important, Case Records Must Be Kept, Integration Is Necessary, and Spiritual Growth is Necessary.

In the general discussion of the principles and in the many practical applications in these booklets one finds an allegiance to the more widely accepted views of "functional" psychologists. There is a conservative use of psychoanalytical and organismic ideas, but the basic structure is essentially eclectic and cautious. The booklets reflect concern with "moral and spiritual values." "Children must learn that the force of religion . . . is a powerful force for keeping life good. Teachers who are concerned about the spiritual life of their pupils do much to . . . solve their problems. . . ." "Children learn more by example than from precept."

These booklets were written primarily to give teachers practical suggestions for dealing with the various types of exceptional children. The suggestions seem to be directed to teachers working in a typical public school in what is probably the most prevalent type of curriculum. They are predominantly suggestions for establishing fruitful working relationships with the individual child and his parents, for securing, within reasonable limits, desirable materials

and equipment, and for moderate modifications and expansions or "enrichment" of the teaching activities.

There is little in the way of suggestions for extensive revision of the curriculum for the special groups.

The booklets abound in recommendation for particular tests and appraisals, group and individual activities and projects, discussions, admonitions and incentives. These are, in the main, clearly and definitely described, and practicable in a typical school. They portray, in brief and concrete form, practices now employed by the "better" teachers in the "better" typical schools. For the less experienced or less informed or less expert teachers, the booklets will be intelligible and valuable.

The suggestions are really very similar basically for each of the four types of "exceptional children," but the emphasis varies considerably. The booklets devoted to the retarded reader and the mentally retarded will appear to give primary emphasis to the basal skills and subject matter, whereas the booklet for "gifted children" shows a far greater concern for music and the arts, practical and scientific projects, and the like. Many educators would insist that the activities sketched for the gifted are even more seriously needed by the handicapped. The reviewer would therefore offer the suggestion (to which the publisher will certainly not object!) that most of the suggestions for each type of "exceptional" child are equally applicable, with modifications, to the others and that the teacher should read them all. The booklet on "problem children" describes a good, practical approach to all children.

The booklet called *Handwriting for Left-Handed Children* by Luella Cole is completely and clearly practical. In 17 pages she describes in detail how to teach handwriting to left-handed children with a minimum of theory, except in the form of statements concerning "why" a particular practice is desirable. This booklet is the answer to the prayer of the busy teacher who is puzzled by this problem.—ARTHUR I. GATES, Teachers College, Columbia University.

FLEXIBLE RETIREMENT; EVOLVING POLICIES AND PROGRAMS FOR INDUSTRY AND LABOR

Geneva Mathiasen, ed.

New York, G. P. Putnam's Sons, 1957, 226 pp.

In the belief that the solution of employment and retirement problems is one of the most serious economic and social challenges of our times, the National Social Welfare Assembly's committee on the aging, together with McGregor Fund, has devoted some five years to the accumulation of facts, opinions and experience pertinent to the fundamental issue: How best to utilize the skills of older workers for their own benefit and the good of society. *Flexible Retirement* is a report of the second phase of this special project; the first phase was reported in a companion volume to this recent publication entitled *Criteria for Retirement.*•

Flexible Retirement is a summary of the reports of four technical committees which considered job requirements and performances, job modification and redesign, preventive health maintenance and rehabilitation, and administration of flexible retirement. On each of these knotty problems inherent in retirement there is presented an objective analysis of the experience of some 500 large and small companies located in various parts of the United

• Geneva Mathiasen, ed., *Criteria for Retirement*, New York, G. P. Putnam's Sons, 1953.

States, only about half of which stipulate retirement at a fixed age in their plans. This analysis includes statements on the several patterns of flexibility in existing programs, the difference that age may or may not make in performance, job flexibility as one element in the success of flexible retirement, and the economics of flexible retirement as estimated at this time. There is also an excellent discussion of employee relations based on a review of the attitudes of unions and workers, the usefulness of preparation for retirement programs and the public relations facet of retirement, which is already beginning to assume genuine importance for both management and unions.

While no definitive recommendations are reached, owing to the current lack of any substantial or systematic longitudinal studies or recording, the findings of these committees support the conclusion of the Arden House Conference on Retirement held in 1952 to the effect that flexible retirement plans are "economically sound and socially desirable."

For those with more than an academic interest in this complex subject of increasing personal and economic importance, there is an excellent although brief bibliography, followed by valuable appendices giving the details of the retirement plans of some seven companies.—OLLIE A. RANDALL, Community Service Society of New York.

ELEMENTS OF A COMMUNITY MENTAL HEALTH PROGRAM

Frank G. Boudreau and Ernest M. Gruenberg, eds.

New York, Milbank Memorial Fund, 1956, 226 pp.

A stocktaking of community mental health activities was the theme of a 2-day meeting of experts sponsored by the Milbank Memorial Fund. The reports of this conference constitute the contents of this publication. On each of four major topics—"Raising the Level of Mental Health in the Community," "The Primary Prevention of Mental Disorders," "Services for People with Mental Disorders: Early Diagnosis and Treatment Services" and "Services to People with Mental Disorders: The Rehabilitation of the Mentally Ill"—a working document was prepared in advance of the meeting. Then, elaborating the subject, a number of competent students of each topic prepared extensive papers. The consolidation in this book of the working documents, the prepared papers and the record of the subsequent group discussions gives a full picture of the current state of mental health activities in the community. The publication provides an excellent overview of the state of mental health consultation to a number of community services such as child health protecting agencies, public health nurses, family agencies and schools.

The list of authors includes such psychiatric dignitaries as Drs. Robert H. Felix, Jules V. Coleman, Gerald Caplan, Paul V. Lemkau and the late Thomas A. C. Rennie. Other participants in the conference were fully as distinguished.

In the section on early diagnosis and treatment services, there is an exciting discussion led by Dr. Arne Querido of Amsterdam, who describes the mental health program in that city. This service for community psychiatric emergencies points to a new and bold attempt to deal with mentally ill people in their homes. Other presentations, equally as interesting, make this symposium an extremely helpful one to readers seeking a review of expert opinion on the development of community mental health programs.—EDWARD LINZER, National Association for Mental Health.

ANNUAL REVIEW OF PSYCHOLOGY, Volume 7, 1956; Volume 8, 1957

Paul R. Farnsworth
and Quinn McNemar, eds.

Palo Alto, Annual Reviews, 1956, 1957. 448 pp., 502 pp.

Expressly designed for psychologists "engaged in teaching and research, and whose background knowledge of the subject is already well-established," the *Annual Review of Psychology* provides an excellent reference resource for mental health workers who are not psychologists but who maintain an active interest in recent research developments in and around their fields.

The 1956 *Annual Review* is divided into 16 sections, the 1957 volume into 18, each prepared by a recognized specialist in the form of an essay-review of the year's output of books and papers in his particular category, followed in each instance by a bibliography of works mentioned in the text. The bibliographies range from 45 to more than 200 entries. Each section is written with noteworthy compactness. The contributors, in making critical evaluations of the research claims and findings of their colleagues, often take pains to state clearly their own biases.

Of special interest to the mental health worker are the sections in both volumes on abnormalities of behavior, psychotherapy, counseling, social psychology and personality. Both volumes also include sections on industrial psychology, assessment, statistical methods, physiological psychology and comparative psychology, along with sections on specific sense organs. The 1956 *Annual* has an interesting review of the research literature on gerontology (later maturity), superseded by one on special disabilities (psychological factors in bodily deformities and handicaps). The 1956 volume has a section on child psychology, significantly changed to developmental psychology in the 1957 *Annual*.

Both volumes have comprehensive author and subject indexes.

This valuable series of psychological reviews should be better known and more widely used in the mental health field.—ALBERT DEUTSCH, Washington, D. C.

ANXIETY AND MAGIC THINKING

By Charles Odier

New York, International Universities Press, 1956. 302 pp.

American psychiatry is fortunate to have this interesting and stimulating contribution on anxiety. The work of the late French-Swiss psychiatrist, Dr. Charles Odier, has been unfamiliar to many English-speaking psychiatrists and those interested in emotional health because he wrote in French. We are therefore most indebted to Drs. Schoelly and Sherfey for their careful translation, and for their choice of this particular work.

Odier demonstrates his familiarity with the principles of modern psychiatry and analysis as well as a special knowledge of the concepts of Piaget. While the book reads well, it is not light reading. Indeed it deserves careful scrutiny; there are many interesting passages which illustrate the depth of thinking of the author.

Odier appreciates thoroughly many of the currently accepted origins of anxiety, and presents a great deal of interesting case material in outlining his ideas.

This book is to be recommended for every serious student of dynamic psychiatry.—HENRY P. LAUGHLIN, M.D., Chevy Chase, Md.

THE CHILD AND HIS WELFARE

By Hazel Fredericksen

San Francisco, W. H. Freeman & Co., 1957. 2nd ed. 364 pp.

The purpose of this book, the second edition of *The Child and His Welfare,* as stated by the author "is to give a broad view of the field of child welfare and to suggest approaches for the worker in this field." In the preface the author indicates that "about three-quarters of the current edition represents changes and additions designed to bring the book up to date and to make it more complete and more useful." Unfortunately, the writer is not familiar with the first edition, and could not obtain a copy for perusal at this time. Lacking first-hand knowledge from which to make a comparison of the two editions, one must assume that the objectives for this second edition, as presented by the author have been fulfilled.

The Child and His Welfare is divided into eight parts with a varying number of chapters in each of these parts. The chapters in turn are divided by subheadings in a fairly typical textbook style. At the end of each chapter there is also a supplementary reading list of books pertaining to the topic under discussion, although these lists do not seem to include many of the more recent books in the field.

Part One contains two chapters, the first of which is entitled "Growth and Development of the Child," the second "The Field of Child Welfare." In some ways these chapters might be considered introductory to the more detailed discussion in the rest of the volume.

Part Two deals with the history of child welfare work, examines the national interest in the needs of children, discusses how these needs are being met, and lastly surveys in a general way the agencies which contribute to and carry out the current public or private child welfare programs.

More specific topics related to various types of welfare needs and programs for children are dealt with in Parts Three and Four. These topics include discussion of health and school programs; the part religion and recreation play in child development; employment protection for the young worker; guardianship and delinquency. To the writer there appeared to be a certain amount of confusion in the individual chapters in that the author seemingly selected general headings for the various sections and then divided these into individual chapters. Some of these chapters could have been placed equally well under a different section heading. There is little, if any, progression from one chapter to another. The understanding of information in any one chapter is not necessarily contingent upon material in the foregoing chapters.

In general, the author shows basic understanding of the philosophy underlying social casework as it is practiced in child welfare agencies today. An obvious attempt is made in more than one instance to call upon authorities in the field of children's work. The writer was particularly impressed with the material in the subheadings "Child Guidance Clinics" and "Growth of Mental Hygiene Work," in which the author has borrowed heavily from other literature in the field. It cannot be known whether or not this would be equally true for other material in this volume with which the reviewer is less familiar.

Part Five, entitled "Substitute Care," is perhaps the most detailed and comprehensive of all of the sections in this book. In this section it is stated that "Neither the institution nor the foster home should be

regarded as the only form of care. Changes in the child's needs or his situation may necessitate interchangeable use of both forms. The focus, in every case, must be kept on serving most adequately a child who is under the care of the agency." It is particularly gratifying to note that the author gives recognition to the concept both of foster home care and institutional care for children and acknowledges that there are some children, as well as some parents, who need and can profit most by the type of service offered in a resident setting, even though for most children foster home care is considered preferable.

The sixth section, "Unmarried Parenthood," is sympathetically written and the author seems to have good understanding of the underlying philosophy in social welfare programs which serve the best interests of children born out of wedlock.

Part Seven, "Need for Special Services," includes discussion of services needed by the child who is gifted or limited intellectually, the child who has a mental or psychological handicap, or one who has certain physical handicaps such as deafness or a visual problem. No attempt is made, however, to consider other types of physical handicaps. The other chapter under the heading of "Need for Special Services" pertains to children in rural areas and to the sociological problems common to the rural community and also considers the need for special programs for children in rural communities.

The final section deals primarily with welfare programs for children in general and the participation of volunteers in these programs. Recognition is given to certain public welfare programs in individual states including Alabama, Indiana, Mississippi and New Hampshire, as well as to some specific private agency programs. The book concludes with a consideration of what is happening to children the world over. In this concluding chapter the author presents in very concise form the thinking brought out at specific meetings at the international level, such as the text of the Declaration of Geneva and the work of the United Nations Children's Fund.

As indicated by the author, this volume is intended primarily to be used as a textbook for the college or university undergraduate level. It has merit as a book which gives in capsule form a general picture of child welfare services and programs as currently practiced in the United States. The author also expresses in the preface the hope that this book might be of value to a wider reading audience such as interested individuals seeking general information regarding the child welfare field. It seems to the writer, however, that the general plan and layout of the book make it more appropriately a textbook for the undergraduate student.—MARJORIE R. LANDIS, D.S.W., Lehigh Valley Guidance Clinic, Allentown, Pa.

PSYCHOLOGY OF ADOLESCENCE

By Arthur T. Jersild

New York, Macmillan Company, 1957. 438 pp.

This is a useful book for parents, youth workers, teachers and adolescents themselves. It is written in a warm and personal manner, yet it sacrifices none of the scientific, analytical approach to the study of adolescent development and behavior. It is highly readable and yet profound, enjoyable and yet demanding of critical study and insight.

In this reviewer's opinion, as a textbook it will be especially welcomed by teachers of adolescent psychology who are interested in guiding students to a thorough understanding of objective facts and findings about adolescence and at the same time

motivate them to face the personal implications of the emotional or inner life of the adolescent for themselves.

Jersild states that "each person has within himself a laboratory in which he can, to some degree, test for himself the meaning and implication of what has been found in the study of others." He stresses that the participant-observer's approach to learning is more important than that of the spectator-observer who stresses the scientific, scholarly, factual approach to an understanding of adolescents.

This idea is not new in the writings of Professor Jersild. Beginning with *In Search of Self*, introduced into the 4th edition of *Child Psychology* and expressed again in *When Teachers Face Themselves*, the idea that understanding others begins with an understanding of self is a central and compelling theme.

The reader is forthrightly introduced to this idea in the chapter entitled "The Place of Adolescence in the Life Span." Here Jersild discusses the issues facing adolescents. The goals of physical, mental and emotional maturity, progress toward vocational responsibility, increased capacity for tolerating aloneness should provoke inquiry into the reader's own unachieved or abandoned goals. The overview of the decisions of adolescents (including education, vocation and mating), areas of stress which Jersild calls economic and sexual unemployment, as well as contending forces arising from the culture and adult confusion also remind the adult and student reader of decisions that have, or would have if faced, enhanced or threatened his own maturity.

The book actually carries the reader along simultaneously on two tracks. One draws heavily on the studies and insights of developmental psychology. A student could not read this book without accumulating facts and theories about the physical, emotional, social and mental development of adolescents. He has a rich store of charts and graphs and the benefit of scholarly interpretation of important, pertinent, recent studies to aid objective understanding. This reviewer studied over a dozen recent texts and found Jersild's inclusive of all and more of the usual facts concerning norms of behavior along with descriptions of comparative studies of physical and mental growth. Principles of growth and development are more than adequately documented with authoritative evidence. The bibliography is extensive and inclusive of published studies and books and unpublished doctoral dissertations.

The second track which concerns the inner life of the adolescent—the implications of objective evidence of development for his feelings and attitudes toward himself—carries the reader into a "feelingful understanding" of adolescence. And herein lies the uniqueness and greatness of this book.

In supporting his excursion into the inner self of the adolescent Jersild derives evidence from the fields of psychotherapy and psychoanalysis. He also introduces into the mainstream of thought the view of the meaning of selfhood as considered in existentialist philosophy, particularly by Tillich. In Chapter 2, entitled "The Growing Self," he defines the self and sets forth the conditions of self development. Then in four succeeding chapters on emotional development he discusses the roles of love, affection, joy, anger, hostility, fear and anxiety in the experience of adolescence. He more than adequately develops the idea that "the emotionally mature adolescent is not one who simply has learned to be prudent in controlling his emotions, but one who has the freedom to draw upon his emotional capacities.

There are excellent chapters on social relationships between the adolescent and

his peers, members of the opposite sex and adults. Phoebe Overstreet contributes a well-documented chapter on vocational development which stresses the psychological aspect of choice and adjustment. One other unusual contribution to a book of this kind is the chapter called "Adolescent Fantasies, Daydreams and Dreams," which reveals a reservoir of material depicting the rich imaginative life of the adolescent and its relevance to a growing concept of self and adjustment to life.

The philosophy of this book is well stated in the last chapter and is commended along with the rest of the book: "The more realistically the adolescent accepts himself the more he will be free to build upon the strengths he possesses to face his weaknesses and limitations, and to venture into the possibilities that lie before him. There is still much in his development that is uncompleted, yet his life has a quality of greatness, for each person is great to the degree that he draws upon his potentialities for growth."—JEANNE L. NOBLE, City College of New York.

CHILDREN AND OTHER PEOPLE: ACHIEVING MATURITY THROUGH LEARNING

By Robert S. Stewart
and Arthur D. Workman

New York, Dryden Press, 1956. 276 pp.

The authors of this book have attempted to present "in concise form material that is basic for both pre-service and in-service teachers" about personality development, child and adolescent development, developmental problems, child learning, influences of groups and influences of adults. To do this in 256 pages is quite a job indeed!

Stewart and Workman state their point of view as follows: "The human organism is complex, and the principles of its organization are as yet only partially known to us; but the organism does have organization, and it is capable of change." No one in the field of social science would disagree with this orientation, and yet how often is it ignored at the action level! Stewart and Workman have undertaken the task of reducing (or should one say expanding?) a point of view to concrete specific actions for teachers and for parents.

The book is divided into seven sections, each of which can be used separately and read as an entity. Part One is devoted to infancy and early childhood; Part Two is on the elementary school years; Part Three discusses adolescence; Part Four is on educational psychology; Part Five on discipline; Part Six on the problem child; Part Seven on the adults around the child. Such an organization makes the book very easy to read and to browse.

The style of writing used should cause no difficulties, even for the under-college student, and yet there is no feeling of the authors' having written down for the sake of creating a dual purpose book—professional and trade. Dryden Press has assisted the authors by producing a book which is a delight to the eye.

In their writing Stewart and Workman make much of the theories of Freud and Lewin. They select that which they feel is pertinent to the case in point. It is an interesting merger of Freud's concepts of development and Lewin's views of social interaction. From these points of view they weld together recommendations for those who work with children.

Rarely does one encounter a research study to bolster theory and practice, and herein lies a weakness in the book. It is painfully true that research with children has too often been at the ethereal level

where it builds only the ego of the researcher. But we have progressed further than this volume would imply. True, Stewart and Workman set out to cover great notions about children and how they live and learn in a few pages, so something had to go. Maybe many a reader will agree that their selective processes were functioning as they should have been. Luckily for us, they did retain their gifted suggestions on how to live with children.

This small book packs a real wallop in its last section, "The Adults Around the Child." This section more than justifies its writing. It is readily apparent that Stewart and Workman have had much experience with children.

They write with real affection and understanding. Their recommendations are replete with specific examples and are skillfully tied to broad human relations and mental health principles and yet there are no "how-to" manual weaknesses.

This book is commended to the parent and the teacher and other adult who works with children. It is not in its best environment as a text.—GLENN R. HAWKES, Department of Child Development, Iowa State College.

MENTAL HYGIENE IN ELEMENTARY EDUCATION

By Dorothy Rogers

Boston, Houghton Mifflin Co., 1957. 497 pp.

This book, Leonard Carmichael says in his introduction, is much more than a program for the prevention of neurotic and psychotic states in childhood or in adult life. "It is rather intended as a constructive approach to the whole activity of early education and to the consideration of the many means that may be employed to develop healthy personalities in each child. The teacher who studies it will learn what is known today of the ways in which the positive attitudes and habits that are basic to normal, happy living can be fostered."

Miss Rogers herself describes the goal of the book as "to help the elementary school teacher and teacher in training achieve a sound working philosophy of mental hygiene in every phase of the educative process." But if such a working philosophy is to be a sound one, she says, the teacher must have some understanding of the general principles that explain the growth of personality, the reasons for maladjustment, and the paths by which the maladjusted individual can be brought back to mental health.

Major sections of the book deal successively with the mental health of the child, mental health and the school, the mental health of the teacher, and evaluation.

At the outset two contrasting teachers are described:

Miss A prides herself on the fact that the children learn when they are in her grade. There is no foolishness here. She means business and every child knows it. There is a prescribed curriculum and it is going to be covered—and mastered. If lessons are not prepared one must miss a play period or stay after school. There is little time for frills like parties or field trips or games. "I am a 6th-grade teacher and I am going to see to it that my children know the 6th-grade work," Miss A tells her friends.

Miss B, on the other hand, maintains a relaxed atmosphere in her classroom. Education is not a do-or-die proposition, but fun—in the sense of deep satisfaction from genuine achievement. Facts are learned, of course, but often simply as a by-product of a group project or field trip. Miss B is just as concerned about Johnny's finding a place in the group as she is about his finding the answer to a problem in fractions. She does

not keep him in from play when he does not meet some academic standard; she believes play is an important part of the curriculum, too. She wants children to become acquainted with books, to be sure. But she believes that learning is more effective when she remembers that the learner is a person.

What is the essential difference between Miss A and Miss B? Simply this: Miss A's teaching is centered on the subject matter, Miss B's is centered on the child.

Teachers should know, Miss Rogers insists, what the mentally healthy individual is like. Admitting freely that the answer is not a simple one, that no single list of traits constitutes the mentally healthy individual, she lists certain characteristics that most well-adjusted people have in common: "Satisfactory relationship to self, satisfactory relationship to society, ability to deal with problems, ability to adapt, positive satisfaction from emotions, an effective way of life."

Miss Rogers is careful to say that "well-meaning teachers with a smattering of psychiatric information can do a good deal of damage," and gives illustrations to prove it. What she hopes is that her book will help teachers to understand how learning affects mental health, and how mental health affects learning; how essential it is to realize that the outlines of personality are defined early in the child's life, that the early elementary school years are of surpassing importance for the right kind of development, and that the teacher is usually the only adult person besides the parent who is in constant contact with the child.

Above all, the author of this book insists on the necessity for teachers to understand the basic assumptions underlying a sound mental hygiene approach—that all behavior is caused and that the causes of behavior are complex. She says:

"Education is concerned with mental health because learning is a necessary tool to attainment of sound emotions, and the condition of one's mental health either aids or obstructs learning. Elementary school years are especially crucial to adjustment, because the outlines of personality are defined early. Moreover, the educative process, as it often functions, involves hazards which are circumvented by the mental hygiene approach. The teacher's role is especially important because she is the only adult with professional training in dealing with children's problems who has constant touch with the child. While the effect of the teacher's own mental health is uncertain, it is generally agreed that it is easier for the well adjusted teacher to make her pupils happy."

In a closing section of her book Miss Rogers stresses the need for "a sound philosophy" underlying the work of teaching. "This philosophy," she says, "must in each teacher's case be unique, reflecting her own individual needs, capacities and experiences; but it should possess at least four basic elements—the *willingness* to accept her own responsibilities as a teacher; the *realism* to acknowledge the limitations of her position; the *will* and *courage* to cope with problems; and the *intelligence* to move in the direction of worth-while goals. She concludes: "If the teacher is to assist the child to realize his fundamental needs in socially acceptable ways, she must have a sound philosophy of mental hygiene. This means, first of all, consciousness of her own vital responsibilities as the only adult in the child's daily environment with professional training in the rearing of children. Nevertheless, in her zeal to help children, she must not lose sight of certain cautions. She should neither be overly emotional in her manner nor interpret mild upsets as deepseated problems. Her basic approach

must be the positive one of providing those classroom experiences which will permit children to practice the behaviors required for happy, effective living."—W. CARSON RYAN, Chapel Hill.

MARRIAGE

By Earl Lomon Koos

New York, Henry Holt & Co., 1957, rev. ed. 344 pp.

In 1933 when the late Dr. Ernest R. Groves published *Marriage,* it was the first textbook designed specifically for college courses in marriage education. Dr. Groves had few guideposts other than his own experience in teaching. His book constituted a milepost in the development of a new field of education which is now represented by curricular offerings in the majority of colleges and universities in this country. The book also served directly or indirectly as a model for many of the marriage texts which have since been published. It was a useful book; this author used it as a text as early as 1934. But, being a first, it was jam-packed and somewhat cumbersome. Many students found it difficult reading. And, of course, it could include as content only what experience and research had made known up to that date.

In 1953 Dr. Koos undertook to re-do *Marriage.* He pruned the tree, so to speak, added material, rewrote, simplified, clarified, introduced research findings unknown to Dr. Groves. The book that emerged was a very good one and was a Groves-Koos blend. Now Dr. Koos has gone a step farther. The revised edition under review is much more Koos and correspondingly much less Groves. The result is a first-rate book fully consonant with the present attitude and approach to collegiate marriage education.

The book is directed to students who expect to become participators in marriage and family life rather than to those who are seeking an analysis of the family as an institution. Its aim is to aid the student in building an adequate philosophy of marriage. To this end, the book presents various points of view. Yet the author is aware of the framework of values within which the student must live. The book is readable. This reviewer shares the author's assumption when he states that he has "deliberately kept from repeating a multitude of research findings of vital concern to the professional worker, but of little interest to the student whose focus is not upon the science but rather upon the art of living in marriage." Pertinent research findings are included and there are useful charts. At the end of each chapter, there are a list of readings and topics for reports and a list of advanced readings.

The book discusses such topics as marriage and the state, the physical and psychological qualifications for marriage, courtship and mate selection, adjustment in marriage, the sexual and economic aspects of marriage, religion, in-laws, children, divorce, marriage in a war-minded world, and growing old in marriage. It is sound and balanced.—HENRY A. BOWMAN, University of Texas.

THEY CRY FOR MERCY

By Gene Janas

New York, Vantage Press, 1957. 236 pp.

The author, according to the blurb on its jacket, worked 14 months in a mental institution, interviewed hundreds of patients and attendants, and studied thousands of case records before writing this book. With this experience and with a background of

several other "exclusive stories that resulted in exposure of corruption in high places, political and institutional, which eventually brought about drastic public house cleaning," he has attempted, with some success, to reveal his own compassion and anger with the plight of the mentally ill.

He has also attempted to touch cogently and validly on what happens inside a mental hospital and what needs to be done for those hospitalized by the age-old scourge of mental illness.

What a pity that he has failed.

The title of the book, *They Cry for Mercy,* evoked in this reviewer the singular reaction of also crying for mercy, for the repetitious use of phrases and clichés, the overly dramatic choice of words and rather inane love sequences constitute a particularly runny frosting on a somewhat unyeasty cake.

Perhaps the victim of his own feelings of anger, the author rushes periodically into rather artificially contrived conclusions that not only are somewhat inarticulately phrased but also leave the reader unable to share in the conclusion, because of the lack of story or character development that would substantiate it.

While there are both fictional and technical deficiencies, including very real oversimplification of the nature of mental illness, Mr. Janis, as an experienced reporter, may be of the opinion that this is the kind of story-telling that appeals to the man on the street (whoever he is). Even if this approach to the problem of the hospitalized mentally ill were successfully and tellingly done, there is the underlying question as to whether a book that is self-styled as one that will "tear your heart out," that is a "graphic throat-tightening revelation" and that has but three characters in the entire story who have any common sympathy or humanity for the sick with whom they work actually contributes constructively to the broad cause of mental health today.

Certainly there are things in most of our mental institutions that we would deplore. Mr. Janis touches on many of these. But just as certainly in most of our institutions there are developments that can be seen as progress, and these Mr. Janis misses completely.—JOHN D. LYMAN, New Jersey Association for Mental Health.

EMOTIONAL ILLNESS: HOW FAMILIES CAN HELP

By Karl R. Beutner
and Nathan G. Hale, Jr.

New York, G. P. Putnam's Sons, 1957. 158 pp.

This book, written "as a practical guide to enable the family to establish and maintain a happy and warm relationship with a relative who is emotionally ill" fills a need that has long been felt. It should provide encouragement and support to the family, and understanding to friends and neighbors.

The book not only offers practical information on procedures, which the family needs to know, but in the process it breaks down the sense of isolation that at such a time overwhelms the family as well as the patient. Through simple and direct language and the use of a number of case histories the relative of a patient begins to understand and accept both his own feelings and the patient's. The realization that one family in five is confronted at some time with the problem of mental illness, that increasingly it is accepted as an illness that can be treated, from which many recover, is bound to make it easier for the family to seek early treatment for the patient and to accept its important role in his recovery. *Emotional Illness* is not a guide to psy-

chiatry nor an explanation of psychological theories. However, it defines the role of the professionals—psychiatrist, psychologist and social worker—and explains briefly the workings of psychotherapy. The authors also describe the kind of situation that the family can handle but stress the point at which the expert should take over. This kind of instruction, which has been available in first-aid manuals in relation to accidents and so forth, has long needed to be spelled out in the field of mental illness.

The brief final chapter on recovery contains an inspiring description of the gains which accompany a "psychological recovery"—the patient "will be able to accept himself and hence be less tense and afraid . . . he will be better integrated than before, better able to meet his own emotional needs and the demands of living."

The bibliography includes Edith Sterns' *Mental Illness: A Guide for the Family*, reprinted in 1957 by the National Association for Mental Health, which is a useful supplement providing factual information and advice not stressed in this volume.—FRANCES HARTSHORNE, Connecticut Association for Mental Health.

FORGING TOOLS FOR MENTAL HEALTH

By Herschel Alt

New York, Jewish Board of Guardians, 1955, Monograph #4. 197 pp.

Mr. Alt reports on the experience in the postwar decade of the Jewish Board of Guardians. An increasing interest in the care of young children, the readiness of parents to seek help, and in mental health were noted. By 1947 a change in focus of the agency's activities began to take place. A reorganization into three divisions—the child guidance institute, the division of community services, and the division of institutional services—was undertaken. Some of the community and preventive activities were given up and new emphasis was placed on methods in child guidance, training of staff, residential programs, experimentation in group therapy, and the study of child development.

Recognizing that the delinquent was primarily a child in trouble, the board continued its interest in child guidance. A review of referrals revealed children were being seen at earlier ages. The proportion of very young children increased steadily. A greater proportion of referrals was made directly by relatives, physicians and medical agencies than by community service agencies and courts. The duration of treatment more than doubled, probably indicating an increase in the severity of the problems.

Agency practice was to distinguish diagnostically several broad categories. Primary behavior disorders were characterized by an abnormal amount of aggressiveness. These included the rejected and unloved children who had not formed satisfying affectional relationships. Another group was made up of anxious children who were classified as neurotic. They had a too strict rather than a too lax superego. Increasing numbers of schizophrenic or atypical children were encountered.

An important procedural decision was to place responsibility for direct treatment with the case worker. The psychiatrist functioned as a teacher. He established the limits of the therapeutic program and evaluated the treatment given.

Group therapy was introduced by Samuel Slavson and major advances were made during the decade under review. It has become an established method in American psychiatry.

Because of the large group of young children encountered the Council Child Development Center was established for the study and treatment of preschool children. The value of intensive treatment for young children and their parents as well as the need for a close relationship between educational tools and therapeutic techniques were reconfirmed.

During the last half of the decade under review the concept of residential treatment gained general usage. The program of the Hawthorn School was altered and new programs were developed—the Stuyvesant Residence Club, the Henry Ittleson Center for Child Research and the Linden Hill School. This was in recognition of the fact that under care by the agency were children whose problems were more complicated and were motivated by emotional rather than economic deprivation.

Without arriving at a final opinion the agency is questioning whether protective services, oriented to child and community protection, can be provided in the same agency whose major program is one dependent on confidential, voluntary, cooperative relationships among parents and children and agency and one in which the primary condition for effective service is the fullest degree of confidence between parent and therapist.

The book illustrates what can be learned through a thoughtful review of carefully provided services. It teaches lessons in administration. The research interests of the agency and its sensitive response to community needs are extended when ten years of experience and organizational changes are studied in retrospect. The book should be read by clinicians, mental health workers and professional and lay people concerned with the care of children.—J. FRANKLIN ROBINSON, M.D., Children's Service Center of Wyoming Valley, Pa.

PSYCHIATRIC ASPECTS OF SCHOOL DESEGREGATION

By the Committee on Social Issues, Group for the Advancement of Psychiatry

New York, Group for the Advancement of Psychitry, 1957, Report No. 37. 95 pp.

"Of course I'm open-minded! But nothing you could possibly say would change my mind!"

Most of us want to believe that we are open-minded and fair in our social beliefs, attitudes and actions. And many of us do succeed in achieving such a laudable state —at least on some important issues. But each of us carries with us, in our adult life, the remnants of our own childhood. Dictating to our current feelings, thoughts and actions, as most of us know, are not only our more recently acquired points of view but a whole array of needs, tendencies, values, attitudes and wishes (often contradictory to each other) which stem from our earliest years and which, although much of it has become unconscious, nevertheless determines how we currently react to significant events in our lives.

When the Supreme Court ruled that public school racial segregation laws were unconstitutional—and even before that ruling came—most of us were aware that here indeed was a challenging issue. The call for desegregation turned the spotlight on all America—the North as well as the South.

For practically everyone the issue had some personal meaning. Unlike other national questions, such as farm price supports or tidelands oil, this issue magnetically evoked conscious and unconscious responses from *all* of us.

By some, the court ruling was greeted with deep satisfaction or with an impatient "It's about time!" Others, however, saw in it a catastrophic error—or worse—an evil

"un-American" decision by a court that had departed from basic American principles.

The multiplicity of individual reactions, the mixed motivations for joy, or concern, or anger are not surprising when we consider that in each of us innumerable combinations of feelings and thoughts—derived from a variety of economic, social, racial, political and psychological orientations—powerfully pull and push us with an intensity and degree often out of all proportion to the stimulating situation.

As Americans we have long doubletalked about our race relations. Our democratic credo, in this respect, has too long been unmatched by our practice. In the matter of public schools, however, the Supreme Court finally said, in effect: From now on *all* our children are equal and will be treated as such. Desegregate!

Realistically noting the major dimensions of this problem, the GAP report, written by some of our country's leading psychiatrists and social scientists, makes some very sober observations. It discusses, thoroughly, the psychological aspects involved both by white and Negro citizens. It examines the psychological harm that segregation does to the *individual*—not only to the Negro child and adult but also to the members of the white segregating group as well. In similar fashion it explores the many details of harm done to the *community* and to our *nation* because of segregation.

The report notes that since prejudice is a symptom of some personality maladjustment (superficial or deep) there is a risk of erroneously interpreting the situation by condemning all pro-segregationists as being abnormal psychologically.

"To conceive of segregation as pathogenic—that is, contributing to maladjustment—is by no means to imply that all those who believe in and advocate segregation are themselves maladjusted or otherwise psychiatrically abnormal. Obviously, many persons in the United States who are free from psychiatric disorders strongly favor segregation for many kinds of reasons. These range from desires for economic and political power, to sincere conviction that continued segregation is the soundest solution to the problem of Negro-white relations."

Obviously neither the demagogue nor those who deliberately pull the strings for segregation for political or economic gain will be much affected by the content of this report. Nor for that matter would this report have any positive effect upon those whose deep-seated prejudices serve as a defense against their own inner insecurities. Of these people, the report says:

"There are a certain number of maladjusted, seriously insecure or anxiety-ridden people who are much more completely in the grip of prejudiced thinking than the average, and who need to retain their prejudices to serve as defenses against their own inner feelings of lack of worth. From this group, on the whole, come the more irrational and violent denunciations and threats regarding the consequences of desegregation. From a psychiatric point of view, the prejudiced attitudes of this group of segregationists reflect emotional disorder, for which the most appropriate remedy would be psychotherapy."

But if the demagogue and the unscrupulous manipulator and the deeply prejudiced individual is not reachable, who is left? The target for educational effort, then, is the pro-segregationist who sincerely believes, out of his earnest thinking and personal experience, that desegregation is dangerous.

It is this group that the authors of the report feel can be helped. And this is by no means a small group. Nor are sincere

pro-segregationists geographically concentrated—they live in the North also. Nor are they all white! Men and women in Massachusetts as well as Mississippi, doctors and ditch-diggers, teachers and tomato-pickers, preachers and pool-hall habitués, the college grad and his mother and dad—you, your neighbor and I—all of us may well be among the many who see desegregation as a dangerous threat.

And for those of us who are so troubled, the authors of the report feel optimistic that factual information can help us. They feel that since serious emotional conflicts are not dictating our conclusions we should therefore be able to perceive and rationally use facts in a mature fashion. They say:

"If such evidence can be brought to the attention of the socially-minded segregationists, it should help to modify some opinions which are not too fixed by emotional conflicts and early conditioning. . . . For such people, reliable and informative reports of successful methods and results with desegregation elsewhere can help to modify misconceptions and disprove needless fears."

But who is to use the report? The report is addressed to the educator, at any level in the school system, the psychiatrist, the psychologist, the social worker, the physician—and, perhaps most important of all, to the citizen-parent.

The question is not: Shall we desegregate our public schools or shall we not? That question, from the point of view of ethics, psychology and democracy, was answered, affirmatively, long ago. The final answer, the legal one, has completed the full reply.

The remaining question is therefore how shall we best proceed? How can we help ourselves and others break through groundless fears and perhaps mildly irrational barriers? The answer, in a very great measure, will be found in this excellent and thorough-going report. It should be studied and discussed by all who desire to understand more about "man's inhumanity to man." And if our prejudices (which we all have in some degree) are not too deepseated —if they serve but a superficial need—the facts and implications for rational action contained in this volume, if properly used, will enable us and our neighbors to live a fuller, more meaningful life.

Buy the book. Study it. Use it.—JULIUS SCHREIBER, M.D., Washington, D. C.

MASTERY OF STRESS

By Daniel H. Funkenstein, M.D.,
Stanley H. King, Ph.D.,
and Margaret E. Drolette, M.P.H.

Cambridge, Mass., Harvard University Press, 1957. 329 pp.

Over the years Dr. Funkenstein and others have devised a number of testing procedures which proved valuable in the management of psychiatric illnesses. In the studies described in *Mastery of Stress* these measures were expanded and applied to a group of 125 Harvard undergraduate students. The results of this program should prove enlightening and stimulating to all who are interested in the origins of psychiatric health and illness.

No summary can convey a complete understanding of the work described in this volume; indeed, its impact depends in large part on its tightly organized and scrupulously planned integration of enormous quantities of diverse information. All of the students were evaluated with clinical interviews, psychological tests and sociological studies. The subjects were then exposed at weekly intervals to three successive stressful situations. The situations involved frustration of the individual either in a

problem-solving situation or when he attempted to recite a story rapidly while hearing a delayed feedback of his own voice. Observations were made of the subject's pulse, ballistocardiogram and emotional reactions before, during and after the stress.

The synthesis of this data indicated that individuals displayed characteristic patterns of coping with the initial acute stress. These were of three main types, each associated with its own physiological response, psychological test fiindings and social position. The patterns were descriptively labeled anger-in, anger-out, and anxiety. When the patterns found in the individual stressful situations were viewed in sequence, however, a second set of patterns emerged. These were two: mastery of stress, associated with diminishing intensity of physiological response, and failure in mastery of stress. Each of these patterns in turn was associated with characteristic psychological responses and personality features.

What the authors have succeeded in demonstrating, therefore, is the fallacy of the one-dimensional notion of "good and bad" kinds of reactions. Instead, in a controlled situation individuals reacted in their own fashion. Whether in succeeding situations their method would be effective or not depended on a second integrative dimension of personality—mastery of stress—which seemed to be derived from other origins than the first dimension reaction-type. Such a demonstration of the greatest importance to psychiatry and should stimulate extensive reevaluation of oversimplified explanations of human behavior.

One cannot make an achievement of this magnitude without any flaws. Serious limitations may be found in this work, some of which are indicated by the authors. The linkage of the physiological data with epinephrine and norepinephrine is, admittedly, theoretical. In addition, it is difficult to accept that the poles of human behavior are anger and anxiety, although these may have been the chief emotions found in the experiments. Finally, the emphasis on "mastery" may be premature; it would be unfortunate of we manage to eliminate oversimplification and value judgments at one dimension only to impose them on a second dimension.

These qualifications, however pertinent, are only relative. The authors have synthesized many viewpoints and many observations. In doing so, they have established a real foothold in a more advanced understanding of human behavior. All students of behavior will profit by their experience.—PETER F. REGAN III, M.D., Payne Whitney Psychiatric Clinic, New York Hospital.

SELECTED CONTRIBUTIONS TO PSYCHOANALYSIS

By John Rickman, M.D.
Compiled by W. Clifford M. Scott, M.D.

New York, Basic Books, 1957, 411 pp.

In these times, when all over the world one sees psychiatric treatment moving toward an emphasis on relationship-therapy, this compilation of John Rickman's work is of an empirical value as a catalyst in this transition.

As one reads these contributions, the sense of the fruitful struggle of the author's lifetime work takes on dimension. For example, starting with a paper titled "Anal Eroticism" and other similar material indicating close adherence to the libidinal theories of Freud to the latter part of the book dealing with such subjects as "The Role and Future of Psychotherapy within Psychiatry" and "The Factor and Number in Individual and Group Dynamics," the

reader comes away with a keen appreciation of the talents and flexibilities that this man went through during his seemingly never-ending desire to continue his own growth and thinking.

Further, after one puts down this book, the appreciation that this man's thinking was leading him into what might be called characterilogical treatment seems to have emerged from the cocoon of the concept of depth therapy. Indeed, in the same vein the reader realizes that Rickman has in this book planted the seeds for the treatment of the character neuroses.

This man's courage to grow beyond the concepts of his training is grounds enough for those in the profession who seek not merely to improve psychiatric treatment with the use of different and new techniques but rather stirs the thinking of the therapist in his concepts of human psychology.

Rickman's comprehension and integration of the allied fields of creativity of the arts and sciences as well as psychiatry's association to education, including medical education, enabled him to give us one of the few clear and communicative expositions on a subject that is too often marred by cliché thinking.

The concise and clarifying discussion on group therapy is similarly illustrative of the questioning mind of the author. And of particular value is the perspective he brings to this subject in elucidating the differences between didactic, reassurance, companionate, confessional and analytic group therapy.

It is indeed quite possible that this book may serve as a jumping-off point for students of human psychopathy as they continue in their own endeavors to further their knowledge of this subject.—CORNELIUS BEUKENKAMP, M.D., New York City.

THE CARICATURE OF LOVE, A DISCUSSION OF SOCIAL, PSYCHIATRIC AND LITERARY MANIFESTATIONS OF PATHOLOGIC SEXUALITY

By Hervey Cleckley, M.D.

New York, Ronald Press, 1957, 319 pp.

The general impression that one gathers in reading this book is that homosexuality is on the increase. This, of course, is an impression, and with the possible exception of the Kinsey report the literature gives no proof. Certainly it is a psychiatric problem which is not local and is not confined to our own culture. So pressing is the problem that in England the Wolfenden committee reported in detail the situation and the social implications of it, with recommendations to the Bar as to how it should be handled. Therefore this book by Cleckley is timely, if not exactly definitive.

One gets the impression from *The Caricature of Love* that homosexuality is an organic maladjustment in variance with the common pattern of heterosexuality. The author is somewhat skeptical of the contributions made by the dynamic psychiatrists and by Kinsey, and his skepticism carries over into the whole question of the bisexuality of the individual. The unconscious apparently is a minor factor and the biological factor is the major one in his experience. He questions also some of our premises that homosexuals are divided into two categories—the active and the passive—which is generally accepted. In his own practice, which is certainly large, these roles are interchangeable and are not dynamically fixed in one category or another. The book does reinforce the confusion which covers this entire field and which the aforementioned committee likewise emphasized.

The homosexual, in Cleckley's experience, is a very unhappy individual, masochistic to an extraordinary degree, and the relationship between the partners is highly charged with discontent, jealousy and sadism. André Gide in his literary contributions to this problem confirms these facts. Why these manifestations of an intimate bond between two individuals should contribute so much unhappiness is a moot question. When one looks back to the early Platonic concept of homosexuality the disparity between the reaction of the partners then and now is extraordinary. Was this a form of defense and self-delusion?

The book leaves one with the impression that the therapist gains deeper understanding and perhaps a certain amount of tolerance, provided the young are not involved. To the child psychiatrist, homosexuality in adolescence is a common and transitory pattern, although Cleckley regards it in a different category entirely. The whole question of the variables in sexuality is left for future investigation, for we are just breaking ground and opening new fields in science.—EDWARD LISS, M.D., New York City.

THE NEUROLOGIC AND PSYCHIATRIC ASPECTS OF THE DISORDERS OF AGING

Joseph Earle Moore, H. Houston Merritt and Rollo J. Masselink, eds.

Baltimore, Williams & Wilkins Co., 1956, 307 pp.

The Neurologic and Psychiatric Aspects of the Disorders of Aging is the published version of the 35th annual meeting of the Association for Research in Nervous and Mental Disease. The brief, neat preface by Dr. Joseph Earle Moore suggests that the program and participants of the symposium were selected with hope that consideration of the neuropsychiatric problems of the aged would be well balanced by discussion of the more fundamental problems of aging and that identification of early and late manifestation of the disorders encountered in the elderly would be accompanied by notes on what to do about them.

The essayists succeed in bringing into focus that a concept of aging may serve as a framework for scientific research and medical treatment. The book contains much old information in compact form, many stimulating ideas well phrased, and some suggestions for future research. Although brief for a book of its kind—the text and discussions comprise only 270 pages—it is not likely to be read consecutively by many but rather read a chapter at a time as curiosity or need dictates. There is, however, cohesion, order and uniformity of tone in the book.

Eleven of 15 chapters review the biology of cellular aging, neuronal life history, brain metabolism, structural brain changes, cerebral blood flow, intelligence, psychopathology, the effect of drugs, experimental prolongation of life span, the epidemiology of mental disorders and genetics as related to the aging process. Neuropsychiatric disorders of the elderly and aged are covered by papers on hypertensive and arteriosclerotic vascular disease of the brain, neurologic changes, and rehabilitation of the patient with neurological disorder, and by a panel discussion on the physician's contribution to the role of older persons in society. The seven contributors to the final section touch on acute breakdowns, retirement, medical management, cultural attitudes, psychotherapy and rehabilitation.

The authors are for the most part distinguished research workers or clinicians. Outstanding is the uniformly good-humored optimistic viewpoint. Lansing's speculation that "senescence is a progressive loss of the ability to live" is followed by Weiss's hopeful thesis that neuronal cellular activity may favor growth and regeneration. He presents evidence that it is the developmental machine which keeps the physiological machine in good repair rather than the physiological machine which fails with aging. Andrew stresses that neuronal cells are actively engaged in a defense against degenerative processes which we may yet learn to reinforce. Lorge's remarks that intellect and the use we make of it are maintained without significant decrement through early and middle maturity implies that the neurophysiological mechanisms remain in good repair for a longer time than many believe. The dietary experiments reported by McKay may provide a clue to the controlled prolongation of the complex processes of growth and repair. If retardation of physiological growth tends to prolong life, as some of his work suggests, we may wonder whether well-planned prolongation of the dependency period of the human being for educational purposes does not prolong the life of the mind. Just as "mind," or the complexity of mental activity possible, appears to depend on the length of the developmental process of the phylum so may preservation of "mind" in the individual organism be related to prolongation and intensity of the learning period. Certainly the better educated persons appear to weather physical changes and socio-economic stress better than do those deprived of opportunity to grow in intellect solidly, broadly and without haste. Kallman's report, however, checks us from too fanciful speculation by underlining that the stuff of which we are made is surely of importance in determining long life and also mental health.

Our understanding of mental disease as a public health problem may be distorted by our methods of diagnosis and classification as well as by our collection of statistics. This is an important contribution in Gruenberg's review. Mental illness of many varieties may persist or develop in old age but may be masked by senile brain damage or masquerade as such. The importance of accurate incidence data, which in turn depends upon accurate diagnosis, cannot be overrated; if available, the figures might prompt large changes in our ideas about the prevention of psychiatric disorder in the aged.

On the clinical side Foley's frank reminder that "little strokes" should not be diagnosed in the absence of reasonable evidence of lacunar infarct may help to controvert some recently developed medical mythology and encourage more careful clinical medical appraisal of aged persons. In his brief chapter Rusk quotes Spiller's words, "action absorbs anxiety." The discussions by the panel contribute suggestions and hints about the form action may take in dealing with problems of retirement, physical disability, and psychological and emotional disturbances in the aged as well as unhealthy societal attitudes toward aging. Zeman reminds us that physical medicine comprises only a part of the aggressive approach to medical problems now known as "rehabilitation" and that "rehabilitation" is a theoretical concept and medical attitude.

It is the impression of this reviewer that the book may help in crystallizing ideas for a medical approach to the elderly and aged. The action we take to handle their problems can mitigate our own fears or relieve

our feelings of guilt and obligation only if it is rational and effective. To decrease the anxiety which stems from our sense of helplessness as we review the helpless dependency of many old persons upon us we must develop more effective ways of relieving their distress, and ultimately prevent the occurrence of much of the mystery which goes under the name of degeneration or deterioration.—ALVIN I. GOLDFARB, M.D., Home for Aged and Infirm Hebrews, New York City.

Notes and Comments

CONNECTICUT MARKS GOLDEN ANNIVERSARY

America's first mental health association formally launched its golden anniversary year with a birthday dinner April 29 in New Haven. On hand to congratulate the 50-year-old Connecticut Association for Mental Health in the birthplace of the mental health movement were 400 well-wishers.

Among them were Dr. Benjamin A. Cohen, of Chile, assistant secretary-general of the United Nations; Dr. John R. Rees of England, director of the World Federation for Mental Health; Dr. G. Brock Chisholm of Canada, first director-general of the World Health Organization; Gov. Abraham A. Ribicoff of Connecticut; Judge Luther Alverson of Atlanta, president of the National Association for Mental Health, and a delegation of four NAMH staff members.

To Mrs. Clifford W. Beers, 80-year-old widow of the nation's pioneer mental health leader, was given the honor of blowing out the candles on the birthday cake. She was also honored with a toast, proposed by Mrs. William S. Hammersley, president of the state association.

President Eisenhower sent greetings, as did scores of other friends here and abroad.

"Because of what happened here in New Haven 50 years ago, thousands of people are today devoting their skill and lives to the treatment and cure of mental illness," Dr. Chisholm told the group. He was presented with the Golden Anniversary Mental Health Award, a gold bell.

It was 50 years ago last April that Clifford Beers and 13 distinguished residents of Connecticut met to organize a state mental hygiene society. A commemorative plaque marks the site of their meeting in what is now the Yale Faculty Club.

RESEARCH

Dr. William Malamud will join the staff of the National Association for Mental Health September 1 as director of research. For some years he has been professor and chairman of the division of psychiatry at Boston University School of Medicine as well as psychiatrist-in-chief at Massachusetts Memorial Hospitals.

Dr. Malamud is president-elect of the American Psychiatric Association. He is also director of the schizophrenia research program conducted through NAMH by the 33rd Degree Scottish Rite Freemasonry, Northern Masonic Jurisdiction, and a consultant to the National Institute of Mental Health. He is, in addition, a director of the American Board of Psychiatry and Neurology.

Is is expected that with the appointment of Dr. Malamud the response from foundations making funds available to NAMH for mental health research will be increased. It is also anticipated that a substantial fund for research will be raised in the Mental Health Campaign this year, with 5% of all funds contributed allocated for this purpose.

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The National Association for Retarded Children has created the Grover Powers research professorship at Johns Hopkins School of Medicine. Dr. Robert E. Cooke is the first to hold the position, which honors Dr. Grover F. Powers, professor emeritus of pediatrics at Yale University and a former member of the pediatrics staff at Johns Hopkins.

LEGISLATION

Calling attention to major gaps in services to the mentally ill, the NAMH is pressing for increased 1959 appropriations for both the National Institute of Mental Health and the Office of Vocational Rehabilitation.

After considerable study of the President's NIMH budget of $37,697,000, NAMH has recommended two to four million dollars more for training psychiatric personnel; four to five million dollars more for research grants; one-half to one million dollars more for government research on drugs used in psychiatry; two to three million for research projects for which no funds are now available; up to a million dollars more for promising research now under way at the NIMH clinical center, at the drug addiction research center in Lexington, Ky. and at St. Elizabeths Hospital, and one million more for grants to the states to help them expand mental health services outside mental hospitals.

NAMH has also recommended an increase of at least $500,000 over the President's budget of $3,600,000 for mental health research and demonstration projects subsidized by the Office of Vocational Rehabiltation. At present, the OVR has funds for only about one in 10 of the promising new research leads in the field of mental health and mental retardation.

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New York State's *Mental Hygiene News* reports that the cost of attending a special school for the mentally or physically handicapped is deductible as a medical expense on federal income tax returns. This ruling was recently incorporated in the final regulations under the Internal Revenue Code of 1954, Section 213.

The official ruling states: ". . . the cost of care and supervision, or of treatment and training of a mentally retarded or physically handicapped individual at an institution is within the meaning of the term 'medical care.'

"It is immaterial for purposes of this subdivision whether the medical care is furnished in a federal or state institution or in a private institution."

CARE AND TREATMENT

Despite an increase in admissions, the population of U.S. mental hospitals continued to decline in 1957. This is disclosed in a survey released last month by the National Association for Mental Hygiene and the American Psychiatric Association. It marked the second year of downtrend in mental hospital rolls after a 25-year climb.

Admissions during the year increased by 5.6% while discharges increased by 9.2%. Taking into account other factors, including a 2.4% reduction in mental hospital deaths, the net drop in population amounted to .5% in state, county and veterans' mental hospitals, thus sustaining a turning point which started in 1956.

Significantly, the continued downtrend was accompanied by an increase in hospital personnel and in expenditures for care and treatment of mental hospital patients.

The number of full-time employees in public mental hospitals rose from 153,715 to 162,885, an increase of 6%.

Expenditures per patient were increased in 1957 from $3.27 a day to $3.64 a day. While the difference amounts to only 37¢ a day per patient, it represents an increase of 11.1%.

Psychiatric and mental health association leaders saw a direct relationship between the increased expenditures for patient care and more personnel and the continued improvement in the mental health situation.

Standards in state and county hospitals are still far below those of veterans' hospitals, the survey shows. Veterans' hospitals spent an average of $10.31 a day per patient and had 71.4 employees per 100 patients as compared to the $3.64 a day in state and county hospitals with an average of 29.4 employees per 100 patients.

Though totals for 1957 are not available, 1956 figures showed that 1,400,000 persons were treated in all U.S. mental hospitals and institutions including state and county hospitals, veterans' hospitals, federal mental hospitals and private hospitals and institutions. These included 1,029,444 in all mental hospitals and 183,691 in institutions for epileptics and mental defectives. During that year 805,731 were treated in state hospitals and 96,436 in veterans' hospitals.

Patients in all mental hospitals and institutions at the end of 1956 totaled 785,400. Admissions that year to all mental hospitals totaled 498,000.

Growing concern for the welfare of the mentally ill was reflected in increased appropriations by states for mental hospital facilities. During 1957, 23 states increased their appropriations per patient by more than 10% and 12 increased the amount by more than 15%.

The most striking increase was noted in Kentucky which spent 57.5% more per patient than in the previous year, bringing up the figure to $3.25 a day.

Thirty-seven states increased the number of full-time personnel per 100 patients. In Kentucky, the increase was 42.3%, or from 21.3 employees per 100 patients to 30.3.

The survey is based on figures appearing in the current *Fact Sheet* compiled by the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health.

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Construction has begun on Pennsylvania Hospital's new psychiatric division, which will have 120 beds for the care and treatment of Philadelphia's needy mentally ill.

"I consider this a tremendous step forward in the direction of providing prompt and effective treatment of patients who require hospitalization and whose best interest is served by admission to an institution close to their homes," said State Welfare Secretary Harry Shapiro. "Many of these patients can and should be treated in a general hospital and they deserve to be treated with the same dignity as the physically ill."

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The American Psychiatric Association has given its achievement award for 1957 to Detroit Receiving Hospital "for the transformation of the hospital's psychiatric department from an 'overcrowded, understaffed bedlam' to a modern, efficient diagnostic center." This is the first time the honor, established eight years ago, has gone to the psychiatric unit of a general hospital. The award consists of a silver plaque and citation.

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New York is building a new school for the mentally retarded and a cottage-type psychiatric hospital for mentally ill children at West Seneca. Up to 3,000 mentally retarded persons of all ages will be cared for, trained and treated at the new school. The hospital will be a self-contained unit accommodating 200 children in separate cottages of 25 patients each.

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The child's own emotional problem accounted for an all-time high of 41.5% of the requests for placement made last year to the Jewish Child Care Association of New York. Comparable percentages for 1956 and 1955 were 36 and 28.8 respectively.

The association is one of the nation's largest voluntary child care agencies.

Disrupted homes—involving the physical illness of one or both of the parents, marital discord or untenable parent-child relationships—resulted in another 26% of the placement requests. Broken homes caused by separation, divorce or death of the parents, as well as the existence of no established home, were responsible for the remainder.

"These figures paint a significant picture of the tensions of our times," observed Louis L. Bennett, executive director. "They also underscore the changed role of child welfare organizations. Where once they were custodial bodies, providing care for children who had no families, today they are primarily treatment agencies, offering a constructive program for troubled children unable to live with their families."

Another meaningful index to the complexity of child care today is the fact that over 55% of the 1,413 inquiries for temporary placement of children received by JCCA last year came from other social agencies. This, Mr. Bennett said, shows that many of the children referred for placement are those who have failed to benefit from guidance and treatment services in the community because of the severity of their problems.

Discharges totaled 173 during the year. The 87 children who had been in the foster home department showed a median length of time in JCCA care of 4 years 4 months. The 52 discharged from the Pleasantville Cottage School, a treatment-oriented institution for emotionally disturbed children, had a median length of care of 2 years 8 months, while the eight who left Edenwald School, an institution for mentally retarded children, had been in JCCA care a median of 6 years 6 months. The 26 discharges from the two group residences for adolescents, Fellowship House for Boys and Friendly Home for Girls, showed a median of 5 years 7 months in care.

A total of 387 psychological examinations were given during the year by Jewish Child Care Association staff and panel psychologists. The number of children receiving initial psychiatric interviews was 332, compared to 231 and 190 in 1956 and 1955 respectively.

Ninety children were in psychiatric treatment during the year, while remedial instruction in reading, arithmetic and speech was given to 193 children. These figures, Mr. Bennett said, reinforced the agency's findings as to the emotional problems of the children now coming into placement.

REHABILITATION

Improved and expanded treatment has brought about a drop in the number of patients in New York mental hospitals for the third straight year. The decrease was 1,200, compared to an average of 450 in the two previous years.

Governor Harriman told the Northeast State Governments Conference on Mental Health that the decrease resulted from an expanded treatment program, including the use of tranqualizers.

During the conference, held in New York City in April, Dr. Francis J. O'Neill, director of Central Islip State Hospital in Suffolk County, N. Y., described a compensated work program for patients. Present jobs range from woodworking to such simple tasks as sewing buttons on cards for sale.

The 25 patients in the pilot project are not approaching financial independence through this work, but Dr. O'Neill hopes the demonstration will show the way toward new methods of rehabilitation and

will help the patients find jobs after discharge.

Dr. Mabel Ross, mental health consultant in the New York regional office of the U. S. Department of Health, Education and Welfare, said unions should be consulted by mental health workers on employment for ex-patients, particularly on wage levels, sheltered workshops and vocational advice.

The conference went on record as advocating that research in mental health be established and maintained by the states on a permanent, stable basis by providing a nucleus of full-time researchers. It also urged that every state mental health agency carry on research as part of a good patient care and treatment program.

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An increasing number of veterans hospitalized by the Veterans Administration for severe mental illness are recovering and leaving the hospital, figures released by the agency May 8 show.

The VA said its hospitals placed 6,736 mental patients on trial visit to their home communities during the first six months of fiscal 1958, and 13,200 during all of fiscal 1957.

The 13,200 represent a 7% increase over the 12,351 patients placed on trial visit from VA hospitals in fiscal 1956, a 32% increase over the 9,985 in fiscal 1955, and a 73% increase over the 7,617 in fiscal 1953.

Most of the patients leaving the hospitals on trial visit have been treated for severe mental conditions, the VA said.

The average daily patient load of mentally ill veterans in VA hospitals has remained at around the same number since the beginning of fiscal 1956, but rose between 1953 and 1956. Currently the figure is 57,423, which includes 52,456 veterans with severe mental illness and 4,967 with less severe psychiatric disorders.

The VA said the increase in patients on trial visit can be attributed to changes in therapies (including introduction of tranquilizing drugs and more emphasis on individual and group psychotherapy), to an increase in open wards, and to reawakened interest in development of new habits of resocialization to prepare patients for return to community living.

TRAINING

Nurses in mental hospitals are training for their growing responsibilities in teaching psychiatric aides in a series of seminars which began in mental hospitals in four southern states in June. The project is sponsored by the National League for Nursing and the American Psychiatric Association and supported by a grant from the National Institute of Mental Health.

The seminars are designed to improve the quality of in-service training for psychiatric aides, who provide much of the care of the mentally ill in hospitals, and thus to improve the nursing care of patients.

The first six seminars will be held during the summer in mental hospitals in North Carolina, South Carolina, Tennessee and Arkansas. The University of North Carolina is providing headquarters and other services for the seminar staff.

Teaching will emphasize the part feelings of patient and nurse play in the patient's therapy, in order to bring about better understanding of interpersonal relations as a factor in the care of the mentally ill. Methods of teaching will also be covered, with participants having opportunity to teach groups of aides under supervision of the seminar instructors.

The project is administered by the NLN

Mental Health and Psychiatric Nursing Advisory Service.

A joint NLN-APA advisory committee has the following members: Dr. Daniel Blain, medical director of the American Psychiatric Association; Lavonne M. Frey, director of nurses at St. Elizabeths Hospital, Washington, D. C. and chairman of the NLN Council on Psychiatric and Mental Health Nursing; Dr. Granville L. Jones, superintendent of the Arkansas State Hospital and chairman of the APA committee on psychiatric nursing, and Kathleen Black, director of the NLN Mental Health and Psychiatric Nursing Advisory Service.

Regional and local planning committees are being organized to help carry the project out in their areas. It is expected by fall to extend seminars to mental hospitals in states other than the four in the pilot phase of the project.

PUBLIC INFORMATION

"The Key," new National Association for Mental Health film on the changing picture of mental illness, has won a "Chris" Award from the Film Council of Greater Columbus, Ohio, as an outstanding film in the medical field.

"The Key" was the only health film cited by the *New York Times* recently in "a quality crop" of five nontheatrical movies. The *Times* reviewer wrote that the film was "a thoughtful, restrained and moving documentary on mental illness, photographed largely inside various hospitals and institutions. The picture underscores general therapeutic advances in the treatment of confinement cases; the terrible plight of the doomed and, even more affectingly, the lonely.

"Without begging, it asks, for outside sympathy, understanding and encouragement in rehabilitation. Principally because of the recorded faces, the plea comes across with quiet, heartbreaking urgency."

Screenings of "The Key" were a main feature of public rallies throughout the country during Mental Health Week, April 27-May 3. The film has also been shown by mental health associations before organizations of all kinds.

Prints of the 31-minute film are available for $145 each from the NAMH Film Library, 267 W. 25th St., New York 1.

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Mrs. Dwight D. Eisenhower formally opened Mental Health Week, April 27–May 3, and launched the annual Mental Health Campaign for funds with which to provide voluntary community services to the nation's mentally ill.

On hand for the White House ceremony April 30 were Judge Luther Alverson of Atlanta, president of the National Association for Mental Health; Frank F. Elliott of Chicago, national campaign chairman, and Mrs. A. Felix duPont, Jr., Wilmington, board member.

In launching the campaign, Mrs. Eisenhower rang the Mental Health Bell and said:

"This bell symbolizes hope for the mentally ill and ultimate victory in the fight against the nation's #1 health problem—mental illness. I hope that the ringing of this bell will be heard in every village, town and city and that it will awaken in the hearts of all Americans the traditional spirit of concern for suffering fellow-Americans."

On behalf of the nation's mentally ill and of all who are contributing to their welfare, 4½-year-old Esta Lee Hirsch of Washington, D. C., presented a mental health lapel pin to Mrs. Eisenhower. Esta Lee's parents are active mental health volunteers.

The White House ceremony marked the kick-off signal for 500,000 Mental Health Bell-ringers who went from door to door soliciting funds for voluntary services to the mentally ill.

It was also the signal for proclamations of Mental Health Week, giving official recognition to the nationwide observance; for public meetings, film showings, open houses at public and private mental hospitals, tributes to oustanding psychiatric aides, and special sermons by clergymen of all denominations; and for billboard, poster, transit, TV, radio, newspaper and magazine publicity about the problems of the mentally ill and the ways mental health associations are helping to work toward a solution of these problems.

* * *

The photography has been completed on "Come Back," first mental health film to be produced in Louisiana.

The movie, sponsored by the Louisiana State Department of Hospitals, depicts the problems a mental patient must face when he returns to his community and job. It is being produced by Mr. and Mrs. Irving Jacoby and will be released through the Mental Health Film Board of New York. The camera work was done by Richard Leacock, internationally known for his work on "The Louisiana Story."

Dr. Loyd W. Rowland, director of the state mental health association, says, "We feel sure this is just the sort of film all the chapters of our association can use to help break down the prejudice against employing persons who have been mentally ill," he said.

* * *

NAMH announced May 1 the selection of the Columbus (Ga.) Enquirer as winner of the 1958 Mental Health Bell Award in recognition of the daily's consistent efforts in the fight against mental illness.

At the same time the association announced special citations will be awarded to the Pittsburgh Post Gazette and, posthumously, to its star reporter, Ray Sprigle, whose reporting focused nationwide attention on the plight of the mentally ill.

Selection of the Enquirer was based on the paper's year-round coverage of developments in the field of mental illness, advocacy of improvements in the treatment and prevention of mental illness, and editorial support of the program and activities of the mental health associations in Georgia.

The citation of the Post Gazette is for its editorial pioneering on behalf of Pennsylvania's hospitalized mentally ill and for "its unremitting concern for their welfare."

Mr. Sprigle, whose articles on mental hospital conditions were a sensation 10 years ago, is cited for his consistent interest in the plight of the mentally ill and his efforts to keep them free of the barbaric conditions to which they were once subjected.

Candidates for the Mental Health Bell Award are newspapers selected throughout the country by state and local mental health associations on the basis of their news and editorial support of mental health. The award is a bronze replica of the historic Mental Health Bell cast in 1953 from chains and shackles once used as restraints in mental hospitals.

Previous winners of the award are the Arizona Republic, 1957; Austin (Texas) American Statesman, 1956; Indianapolis Times, 1955; Hartford Courant, 1954 and Baltimore Sunpapers, 1953.

AWARDS

For their kindness, skill and devotion in caring for the patients in their charge, 126 ward attendants in mental hospitals

throughout the U. S. have been selected for National Association for Mental Health achievement awards.

At special ceremonies during May, each winner received an NAMH gold pin and a certificate of achievement in tribute to "the special skills in practical human relations which form such a vital part of the treatment and recovery of the mentally ill."

The recipients, 70 women and 56 men, represented 126 mental hospitals in 39 states and the District of Columbia with a total of 323,297 patients. They were nominated from among 52,932 psychiatric aides by their co-workers, patients and visitors. Final selections were made by local committees representing hospital staffs and boards.

"The purpose of these awards is to focus public attention on the important role of the psychiatric aides, to help them win adequate recognition and acceptance and to encourage higher standards of on-the-ward care," said Judge Luther Alverson, NAMH president.

"Of all the members of the staff, only the psychiatric aide is in constant and intimate contact with the patient, and he thus becomes the primary pillar of reassurance and stability and hope through times of anxiety, elation and despair," he said. "In many cases it is the aide's calm and constant humane attentiveness that chiefly shapes the patient's response to treatment."

The awards are part of a program spearheaded by NAMH since 1944, and the association is pledged to continue its efforts on behalf of the psychiatric aide "until such time as optimal realization of their professional aspirations is assured."

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Dr. Alistair William MacLeod, assistant professor of psychiatry at McGill University, Montreal, is the seventh winner of the $1,000 Isaac Ray lectureship award of the American Psychiatric Association. The award is given annually to a psychiatrist, a lawyer or a judge for an outstanding contribution to furthering understanding between two professions—psychiatry and the law.

As recipient, Dr. MacLeod will deliver a series of lectures on psychiatry and the law in the next academic year at the University of Manitoba in Winnipeg, under the auspices of that university's schools of law and medicine.

Dr. MacLeod, 41, is a native of British Columbia. His medical training at Glasgow and Edinburgh universities in Scotland included postgraduate training in public health and tropical medicine. This was followed by training in psychological medicine at the University of London. He also studied law at the Inner Temple in London and completed training at the Institute of Psychoanalysis there.

Dr. MacLeod has been active in penal reform in Canada for years. He helped organize a group psychotherapy program for prisoners at the St. Vincent de Paul Penitentiary in Quebec with the approval of the Federal Commissioner of Penitentiaries and with the assistance of the professional staff of the John Howard Society. Long active in community mental health work in Montreal, he has been on the staff of the mental hygiene clinic there since 1951. He is also on the staff of Royal Victoria Hospital and consultant to the Protestant school board of the city of Westmount. He is a member of the Royal College of Physicians (London), of the American Psychiatric Association, the American Psychoanalytic Association and the Canadian Psychoanalytic Society, of which he is a past-president.

The award commemorates Dr. Isaac

Ray, a founder of APA, whose remarkable *Treatise on the Medical Jurisprudence of Insanity,* published in 1838, was for many years the standard work on the subject.

Others who have won the APA award are Dr. Manfred S. Guttmacher, chief medical officer of the Supreme Bench of Baltimore, Md.; Dr. Philip Q. Roche, Philadelphia psychiatrist; Dr. Winfred Overholser, superintendent of St. Elizabeths Hospital, Washington, D. C.; Dr. Gregory Zilboorg, New York City psychiatrist; Hon. John Biggs, Jr., chief judge of the U. S. Court of Appeals, Wilmington, and Prof. Henry Weihofen, College of Law, University of New Mexico.

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MEETINGS

The World Federation for Mental Health will hold its 11th annual meeting August 24–29 in Vienna with the Austrian Association for Mental Health as host. Carrying out the theme of uprooting and resettlement, addresses and discussions throughout the meeting will focus on the psychological and sociological aspects of the problems of refugees and migrants in all parts of the world.

The topics for 12 discussion groups are child and adolescent refugees (their problems of transition between cultures—the old and the new); community formation in long-term residence (camps, hospitals, prisons, etc.); tradition and identification in the refugee situation; mental health aspects of family life (separation and reunion); fear, apathy and aggression related to uprooting; governmental and community attitudes and the value of new populations in cultural and mental health terms; social integration and acculturation (value of group techniques); attitudes and mental health problems of long-term refugees and those recently uprooted; training for work with refugees; learning from refugee problems for mental health work in the "normal" community; human rights and refugees, and spiritual values and mental health in relation to rapid cultural change.

The federation consists of 103 associations in 43 countries and 7 trans-national associations. U. S. members include the Academy of Religion and Mental Health, American Association of Marriage Counselors, American Association on Mental Deficiency, American Group Psychotherapy Association, American Neurological Association, American Nurses' Association, American Occupational Therapy Association, American Orthopsychiatric Association, American Psychiatric Association, American Psychoanalytic Association, American Psychological Association, American Psychosomatic Society, American Society of Adlerian Psychology, American Society of Group Psychotherapy and Psychodrama, Association for the Advancement of Psychoanalysis, Austen Riggs Center, Child Study Association of America, Group for the Advancement of Psychiatry, Hogg Foundation for Mental Hygiene, Menninger Foundation, Mental Health Film Board, Michigan Society of Neurology and Psychiatry, National Association for Mental Health, National Association of Social Workers, National League for Nursing, Postgraduate Center for Psychotherapy, Society for Applied Anthropology and the William Alanson White Psychoanalytic Society.

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The 5th annual meeting of the Academy of Psychosomatic Medicine will be held October 9–11 at the Park Sheraton Hotel in New York City. The program will focus on the psychosomatic aspects of internal medicine and will include formal papers, panel discussions and luncheon

conferences. The meeting will be open to all scientific disciplines, psychologists, social workers and nurses.

Further information is available from Dr. Bertram B. Moss, Suite 1035, 55 E. Washington St., Chicago 2.

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Tentative plans for the 8th annual meeting of the National Association for Mental Health were to be put before the national board at its June 21 meeting in New York City.

The annual meeting and National Mental Health Assembly will be held the week of November 17 at the Hotel Muehlebach in Kansas City.

The preliminary plans call for general sessions, workshops and business sessions built around the general theme of putting more people to work as voluntary recruits in the fight on mental illness. Program sessions will focus on the hospitalized mental patient, the patient returning from the mental hospital to the community, mental health education, and methods and materials.

Teenagers will give a special performance of the latest NAMH play—"Which Way Out?"—at a session devoted to audio-visual aids in mental health education.

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The nation's first regional conference on mental retardation, held March 11–13 in Chicago, was opened with an address by Dr. George S. Stevenson, NAMH consultant. Eighty delegates from Indiana, Michigan, Ohio, Wisconsin and Illinois exchanged ideas and experiences with the aim of improving services for the mentally retarded in the midwest.

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For three weeks beginning May 26, the U. S. was host in Minneapolis to the World Health Assembly, governing body of the World Health Organization. About 600 delegates, alternates, advisers, observers and staff members attended the meeting, first of its kind in this country.

WHO, which celebrates its 10th anniversary this year, was set up by 88 countries to coordinate international health work and help governments, on request, in fighting disease and in strengthening their health services. With WHO assistance the Jordanian government, for example, is establishing a modern mental health service.

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Step up your efforts to recruit high school and college students for mental health careers!

This is the plea coming out of the Midwestern Conference on Mental Health Manpower held April 29–30 in Chicago under the auspices of the Council of State Governments.

Mental health associations and others concerned about the shortage of psychiatrists, psychologists, psychiatric nurses and social workers were urged to intensify their work with schools. They were specifically asked to interest more high school students in science courses leading to eventual careers in psychiatry, mental hospital administration and other mental health fields.

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"Disadvantaged youth" are to get special attention from the National Child Labor Committee in a new program adopted in May by the board of the 54-year-old social agency. The new program singles out the children of agricultural migrants and low-income farm families, school drop-outs, the so-called "uneducables," and members of minority groups.

Eli E. Cohen, the committee's newly appointed executive secretary, said, "The National Child Labor Committee's historic battle against exploitative child labor (as

it existed early in the century) has nearly been won. Our board has been involved in an intensive reevaluation to determine the best way to extend our original objectives to modern-day conditions in order to serve today's children and youth. The board has emerged from its deliberations with a vital program that steps up our emphasis on activities designed to help young people prepare for, look for, get and hold constructive jobs. In line with our long tradition of concern for the exploited, disadvantaged youth will get particular consideration.

"The National Child Labor Committee will promote the best educational and employment opportunities for all young people."

The committee will continue to protect young people against exploitative child labor where it still exists, especially in agriculture. It will also maintain a "watchdog vigilance" over child labor legislation and its enforcement and will promote needed regulation in such areas as agriculture.

In addition, the committee will work closely with other organizations that help youngsters develop vocationally or protect them from harmful jobs. Its activities will involve schools, employers and citizens. It will develop and stimulate programs to help students bridge the gap between school and work and will promote the extension of educational opportunities, particularly for migrant children.

The National Child Labor Committee was chartered by Congress in 1907 to promote the welfare of America's working children.

* * *

The president of the American Psychiatric Association declared May 12 that America's large public mental hospitals were "bankrupt beyond remedy" and should be "liquidated" as soon as other facilities can replace them.

Dr. Harry S. Solomon, emeritus professor of psychiatry at Harvard Medical School and superintendent of the Massachusetts Mental Health Center in Boston, said in his APA presidential address that hardly a state mental hospital has an adequate staff nor any likelihood of getting one. Young physicians and other professional people are not attracted to them. Thus, he said, they cannot be made into true hospitals.

Challenging Dr. Solomon's view was Dr. Mesrop A. Tarumianz, chief psychiatrist for Delaware, who declared that a third of the public mental hospitals inspected by APA so far had been approved either fully or conditionally.

Dr. Tarumianz said that of 215 large public hospitals inspected to date 24, or 11%, had been fully approved and 51, or 23%, had been conditionally approved. He predicted that "no liquidation of large hospitals will occur in this country for many years to come, possibly 20 or 30 years."

He observed that the size of a hospital was not always a good criterion for determining whether it offered good or bad facilities for the care and treatment of patients. "There are many small psychiatric hospitals, private as well as public," he asserted, "that do not have as good facilities and services as some of the larger institutions have."

Dr. Solomon cited several alternatives to the state hospital for acutely ill patients who respond readily to treatment, including psychiatric units in community general hospitals; private practitioners; small psychiatric hospitals for intensive treatment; out-patient clinics; day hospitals and night hospitals where patients can be treated while they work or reside in the

community; halfway houses and other aftercare and rehabilitation facilities; and special units for children and the aged whose needs cannot be met in the wards of large state hospitals.

He warned, however, that until medical science advances further there will remain a large number of patients who do not respond to treatment. "Their prospect remains grim," he emphasized, "unless new ways are found to meet their needs. They will be sent to the large mental hospitals where they will accumulate in an atmosphere of gloom, despair and deterioration. We cannot allow this to happen."

For those chronic patients who do not respond to treatment, Dr. Solomon recommends a new type of facility not so much like a hospital as like a home or colony of moderate size. It should provide adequate medical service, including psychiatric, but it should focus mainly on vocational and social rehabilitation activities to help the disabled patient make the best possible adjustment according to his capacity.

Dr. Solomon ventured that a new profession might be developed for the management of these individuals, based possibly on the kind of skills found among city planners, group social workers, educators, public health workers, administrators and the like.

He also called attention to the APA's growing leadership role in finding more effective ways of dealing with mental illness. He paid tribute to the association's first medical director, Dr. Daniel Blain, who took the job in 1948. His successor, appointed in May, is Dr. Matthew Ross, assistant clinical professor of psychiatry and psychology at the UCLA Medical Center.

In ten years' time, Dr. Solomon said, the association's budget has grown from about $60,000 to nearly a million dollars yearly. It has developed standards for mental hospitals, inspected and rated them, and provided a wide range of information and consultation services for them. It has set up a democratic assembly to help guide the association's affairs, composed of representatives of district branches in nearly every state. Its membership, now over 10,000, has doubled. It has acquired a new headquarters building in Washington, D. C.

The psychiatrist leader also recommended that APA consider liberalizing its membership requirements. He stressed how fundamental were the contributions of many others in a total attack on mental illness such as neurologists, physiologists, biologists, pharmacologists, nurses, psychologists, social workers and others. He urged that these be brought into closer relationship with the association, if not as members, then at least in some meaningful fashion. They would broaden the outlook of psychiatry and strengthen the APA in its leadership role, he concluded.

Dr. William Malamud, professor and chairman of the department of psychiatry at Boston University School of Medicine and chief of psychiatry at the Massachusetts Memorial Hospitals in Boston, is the new APA president-elect. He will take office as president a year hence.

Two vice-presidents were elected: Dr. William B. Terhune, medical director of the Silver Hill Foundation, New Canaan, Conn., and associate clinical professor of psychiatry at Yale University School of Medicine; and Dr. David C. Wilson, professor and chairman of the department of psychiatry and neurology at the University of Virginia School of Medicine.

The new secretary is Dr. C. H. Hardin Branch, professor and chairman of the department of psychiatry at the University of Utah School of Medicine, and the new treasurer is Dr. Robert H. Felix, director

of the National Institute of Mental Health.

The association named three honorary fellows: Helena T. Devereux, founder of the Devereux Schools for exceptional children; Albert Deutsch, historian of psychiatry and the treatment of the mentally ill, and George E. Bushnell, sovereign grand commander of the Supreme Council, 33rd Degree Scottish Rite Freemasonry, Northern Masonic Jurisdiction, for a quarter of a century a staunch supporter of research in schizophrenia.

Dr. Francis J. Gerty, professor and chairman of the department of psychiatry at the University of Illinois College of Medicine, took office as president at the end of the meeting.

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The 36th annual meeting of the American Orthopsychiatric Association will be held March 30–April 1, 1959 at the Sheraton-Palace Hotel in San Francisco. This will be the first AOA meeting on the west coast.

NEWS FROM ABROAD

Eight times more bachelors than husbands were admitted to British mental hospitals with schizophrenia, according to a statistical review released in May by the Registrar General for England and Wales.

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The number of psychiatrists in the Soviet Union has increased from 2,200 to 5,000 since World War II, E. A. Popov, delegate from the USSR, reported at a psychiatric seminar sponsored in Denmark this spring by the World Health Organization.

PUBLICATIONS

The proceedings of a conference on day hospitals, held March 28–29, 1958 in Washington, constitute a helpful guide for all who are interested in the concept of part-time hospitalization.

The illustrated booklet provides information and recommendations on a theoretical rationale for the day hospital, personnel, activities (including sample weekly programs), physical facilities (including a suggested layout), equipment, selection of patients, and special features.

Copies are available for $2 each from the Architecture Study Group, American Psychiatric Association, 1700–18th St., N.W., Washington.

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A guide for establishing fee policies in voluntary psychiatric outpatient clinics is detailed in a study published recently by the Community Council of Greater New York.

It answers such questions as why, by whom, how and what fees should be charged.

A study of fee charging in New York City clinics, made in 1956 by the council, revealed that 3 out of 4 charged fees of some or all patients. Lack of a community-wide pattern, however, led to the establishment of guiding principles. These are contained in the new study, *Guiding Principles for Fee Charging in Voluntary Psychiatric Outpatient Clinics.*

Copies are available for $1 each from the Community Council of Greater New York, 345 E. 45 St., New York 17.

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New developments in research, the training of psychiatric personnel and the care, treatment and rehabilitation of the mentally ill are summarized briefly in a new pamphlet issued by the National Institute of Mental Health.

The pamphlet, called *Facts on Mental Health and Mental Illness,* also supplies

statistics on the mentally ill in the U.S. and on the cost of mental illness. To spur public action it lists jobs in the mental health field that need to be done.

Single copies are free on request from NIMH, Bethesda 14, Md. Quantities are available at the rate of 10¢ a copy from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D. C.

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Cameron House, a San Francisco community center, is distributing a Chinese translation of the popular National Association for Mental Health leaflet, *What Every Child Needs for Good Mental Health.*

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A new report on mental health clinics—their characteristics, geographic distribution and professional staff—has been released by the U.S. Public Health Service.

The information it contains should be of help to local, state and national mental health program administrators, legislators, clinicians and mental health associations in charting the development of clinics.

The report, titled *Outpatient Psychiatric Clinics in the United States 1954–55,* is published as Public Health Monograph No. 49 (Public Health Service Publication No. 538) and is available for 60¢ a copy from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D. C.

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Over 100 agencies and individuals are listed in a new *Directory of American Psychological Services—1957* published recently by the American Board of Psychological Services. Individual and industrial psychologists are named, along with psychiatric clinics and other medical institutions offering psychological services.

A new quarterly journal, *International Social Work,* made its appearance last January. It is published by the International Conference of Social Work and the International Association of Schools of Social Work.

Volume 1, Number 1 contained the proceedings of the 8th International Congress of Schools of Social Work, a report on the 11th session of the United Nations' Social Commission, articles on social work philosophy and international coordination of social services, and organizational news and notes.

Subscription rates are $4 for North, Central and South America, $3.50 for Europe and the Middle East, $3 for Asia. The publication may be ordered from the International Conference of Social Work, Room 1017, 345 E. 46th St., New York 17.

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The American Group Psychotherapy Association has published two separate abstracts covering the scientific papers presented at its 1957 and 1958 conferences. These original papers serve as a comprehensive survey of current work in group psychotherapy. The two abstracts are available from AGPA, 1790 Broadway, New York 19, for $1 each.

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More than 100 general hospitals are using Ford Foundation grants to offer early treatment of mental illness and thus relieve overcrowding in mental hospitals.

Some, the foundation reports, have hired liaison psychiatrists to accompany the medical staff on regular hospital rounds and evaluate the emotional components of their patients' illnesses. Others have opened psychiatric or mental hygiene clinics.

The foundation holds that when a general hospital provides the proper facilities it is easier in many ways to treat mental

patients there than in a large specialized institution. There is less stigma attached to treatment, and the patient is nearer his home and his work. The mildly disturbed patient, the foundation notes, can visit a hospital's outpatient clinic by appointment and continue to live at home and carry on with his family life and his job.

The foundation presents this point of view in a booklet, *The Difference It Makes,* one of a series on activities supported by Ford Foundation grants. The booklet is available from the foundation's office of reports, 477 Madison Ave., New York 22.

* * *

A booklet describing life in state mental hospitals has been published by the New York State Department of Mental Hygiene. Called *Give Them Your Hand,* it is designed to help the families of newly admitted patients work with hospitals to promote recoveries.

Warm, sympathetic and reassuring in tone, the booklet explains what happens to the patient in the hospital and points out the role of the relative. Its theme is that after a patient is admitted, hospital and family must work together to make him well.

A special edition for each New York State hospital contains helpful information about visiting days and other details.

MENTAL HYGIENE

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Articles

Book Reviews

NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Voluntary Promotional Agency of the Mental Hygiene Movement founded by Clifford W. Beers

OBJECTIVES: The National Association for Mental Health is a coordinated citizens organization working toward the improved care and treatment of the mentally ill and handicapped; for improved methods and services in research, prevention, detection, diagnosis and treatment of mental illnesses and handicaps; and for the promotion of mental health.
